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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Members of the Integration Joint Board

Town House,
ABERDEEN Date Not Specified

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in **Rooms 4 & 5, Health Village on TUESDAY, 3 SEPTEMBER 2019 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

DECLARATION OF INTERESTS

1 Members are requested to intimate any declarations of interest (Pages 3 - 4)

DETERMINATION OF EXEMPT BUSINESS

2 Members are requested to determine that any exempt business be considered with the press and public excluded

STANDING ITEMS

3 Minute of Previous Board Meeting - 1st July 2019 (Pages 5 - 16)

4 Draft Minute of Audit and Performance Systems Committee - 20th August 2019 (Pages 17 - 18)

5 Draft Minute of Clinical and Care Governance Committee - 13th August 2019 (Pages 19 - 20)

6 Business Planner (Pages 21 - 24)

7 Chief Officer Update (Pages 25 - 52)

TRANSFORMATION

8 Strategic Commissioning (Pages 53 - 90)

9 Transformation Report (Pages 91 - 124)

10 Primary Care Improvement Plan (Pages 125 - 152)

11 Action 15 (Pages 153 - 196)

12 Alcohol Drug Partnership Update (Pages 197 - 212)

STEWARDSHIP

13 Meeting Dates 2020 2021 (Pages 213 - 218)

14 Standards Officer Report (Pages 219 - 222)

PERFORMANCE REPORTS

15 Winter Plan (Pages 223 - 248)

16 Annual Report (Pages 249 - 290)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

17 Procurement and Contracts Update (Pages 291 - 294)

Website Address: https://www.aberdeencityhscp.scot/

Should you require any further information about this agenda, please contact Derek Jamieson, tel 01224 523057 or email derjamieson@aberdeencity.gov.uk

You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether reports for meetings raise any issue of declaration of interest. Your declaration of interest must be made under the standing item on the agenda, however if you do identify the need for a declaration of interest only when a particular matter is being discussed then you must declare the interest as soon as you realise it is necessary. The following wording may be helpful for you in making your declaration.

I declare an interest in item (x) for the following reasons ……
For example, I know the applicant / I am a member of the Board of X / I am employed by…
and I will therefore withdraw from the meeting room during any discussion and voting on that item.

OR

I have considered whether I require to declare an interest in item (x) for the following reasons …… however, having applied the objective test, I consider that my interest is so remote / insignificant that it does not require me to remove myself from consideration of the item.

OR

I declare an interest in item (x) for the following reasons …… however I consider that a specific exclusion applies as my interest is as a member of xxxx, which is

(a) a devolved public body as defined in Schedule 3 to the Act;

(b) a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme;

(c) a body with whom there is in force an agreement which has been made in pursuance of Section 19 of the Enterprise and New Towns (Scotland) Act 1990 by Scottish Enterprise or Highlands and Islands Enterprise for the discharge by that body of any of the functions of Scottish Enterprise or, as the case may be, Highlands and Islands Enterprise; or

(d) a body being a company:-

i. established wholly or mainly for the purpose of providing services to the Councillor's local authority; and

ii. which has entered into a contractual arrangement with that local authority for the supply of goods and/or services to that local authority.

OR

I declare an interest in item (x) for the following reasons……and although the body is covered by a specific exclusion, the matter before the Committee is one that is quasi-judicial / regulatory in nature where the body I am a member of:

- is applying for a licence, a consent or an approval
- is making an objection or representation
- has a material interest concerning a licence consent or approval
- is the subject of a statutory order of a regulatory nature made or proposed to be made by the local authority…. and I will therefore withdraw from the meeting room during any discussion and voting on that item.

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Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN, 11 June 2019.

Minute of Meeting of the INTEGRATION JOINT BOARD.

Present: - Councillor Sarah Duncan, Chair; Luan Grugeon, Vice Chair; and Mike Adams, Cllr Gill Al-Samarai, Councillor Philip Bell, Kim Cruttenden, Jim Currie, Councillor Lesley Dunbar, Caroline Howarth, Heather MacRae, Dr Malcolm Metcalfe, Graeme Simpson, Alex Stephen and John Tomlinson.

Also in attendance: - Angela Scott (ACC Chief Executive), Jess Anderson (ACC, Legal)

Apologies: - Dr Howard Gemmell, Alan Gray, Gill Moffat, Faith-Jason Robertson-Foy, Kenneth Simpson and Sandra Ross

WELCOME FROM THE CHAIR

1. Welcome and Introduction

The Chair welcomed all to the Board meeting including Kim Cruttenden and John Tomlinson on their confirmed appointments to the Board. Apologies were received from Alan Gray, Howard Gemmell and Sandra Ross.

The Board heard that Adam Coldwells, Chief Officer of Aberdeenshire Health and Social Care Partnership, (AsHSCP) and Pam Gowans, Chief Officer of Moray Health and Social Care Integration (MHSCI) would be joining the meeting around 11.00am to present Item 14 on the agenda.

Item 18 on the agenda was removed from today's business as a duplication of Item 16.

The Board heard discussion on the exclusion of the Chief Officer's update from the public and it was agreed that this would be reviewed on return of the Chief Officer from holiday.

MEMBERS ARE REQUESTED TO INTIMATE ANY DECLARATIONS OF INTEREST

2. The Chair requested members to declare any interests in today's business.

The Board resolved to :-
(1) Note the following declarations of interest

INTEGRATION JOINT BOARD
11 June 2019

(i) John Tomlinson declared an interest in Item 16 as a provider of consultancy and coaching support to Inspire and intended to withdraw.
(ii) Councillor Al-Samarai declared an interest in Items 11 as a Volunteer Befriender and Item 14 as a member of the Alcohol and Drug Partnership but did not intend to withdraw.

MEMBERS ARE REQUESTED TO DETERMINE THAT ANY EXEMPT BUSINESS BE CONSIDERED WITH THE PRESS AND PUBLIC EXCLUDED

3. The Chair indicated that Items 16 and 17 were considered exempt business and would be heard in private.

The Board resolved to :-
Agree that Items 16 and 17 would be held in private.

MINUTE OF BOARD MEETING 12 MARCH 2019 (BUDGET)

4. The Board had before it the Minute of the Board Budget Meeting of 12 March 2019.

The Board resolved to :-
Approve the minutes as a true record

MINUTE OF BOARD MEETING OF 26 MARCH 2019

5. The Board had before it the Minute of the Board Meeting of 26 March 2019.

The Chair indicated that there were two minor errors within the minute.

Firstly, at Item 9(vi) at reference to appointment of the Chair of the APS Committee and secondly at Item 22 with reference to the Banks O'Dee.

The Board resolved to :-
(1) At Item 9(vi), delete 'and appoint Councillor Dunbar as Chairperson of APS Committee' and replace with 'and appoint Councillor Dunbar as Chairperson of CCG Committee', and
(2) At Item 22, delete 'Bridge of Dee' and replace with 'Banks O'Dee', and
(3) Otherwise note the minute as a true record.

INTEGRATION JOINT BOARD
11 June 2019

MATTERS ARISING

6. The Chair raised the matter of the appointment of members to Chair of the APS and CCG Committees. This had been discussed as referenced at Item 9 of the Minute of the Board Meeting of 26 March 2019.

The Chair confirmed that following the appointment of John Tomlinson to the Board, it was intended that he would assume the Chair of the APS Committee and that Luan Grugeon would continue as a member of that committee.

The Board heard that Kim Cruttenden and Alan Gray would join the CCG committee which would continue with Councillor Dunbar as the Chair.

Following decisions arising from Item 9, Appointments at IJB Meeting on 26 March 2019,

The Board resolved to :-

(i) Allocate John Tomlinson to the APS Committee and as Chair of the APS Committee
(ii) Allocate Kim Cruttenden and Alan Gray to the CCG Committee

DRAFT MINUTE OF CLINICAL AND CARE GOVERNANCE COMMITTEE - 14 MAY 2019

7. The Board had before it the draft minute of the meeting of the CCG Committee from 14 May 2019.

The Chair reminded members that the purpose of the draft minutes appearing on the Board Agenda was for awareness and noting only. The Chair reaffirmed that minutes would be considered for approval by the respective committee.

The Board resolved to :-
Note the content of this draft minute and reaffirmed that the minutes are approved at the respective Committee.

DRAFT MINUTE OF AUDIT AND PERFORMANCE SYSTEMS COMMITTEE - 28 MAY 2019

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11 June 2019

8. The Board had before it the draft minute of the meeting of the APS Committee from 28 May 2019.

The Chair reminded members that the purpose of the draft minutes appearing on the Board Agenda was for awareness and noting only. The Chair reaffirmed that minutes would be considered for approval by the respective committee.

The Board resolved to :-
Note the content of this draft minute and reaffirmed that the minutes are approved at the respective Committee.

BUSINESS STATEMENT

9. The Board had before it the Business Statement which was presented by Alex Stephen, Chief Finance Officer.

The Board heard an explanation on each item including those matters which had been presented and were intended for removal.

The Board heard there was a desire at the APS Committee for greater awareness of future business and that to maintain assurances, completed business be captured appropriately.

The Chair advised that similar comments had been made at the CCG Committee.

Alex Stephen assured the Board that these observations had been acted upon and that work was already ongoing to produce an enhanced Business Planner for the Board and its respective committees.

The Board resolved to :-
(1) Agree removal of Items 1, 4 and 9.
(2) Note the content of the Business Statement
(3) Note that a revised document was being developed

NO REPORTS

10. No Reports

INTEGRATION JOINT BOARD
11 June 2019

MSG SELF EVALUATION FOR THE REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE

11. The Board had before it the report which was presented by Alison Macleod, Lead Strategy and Performance Manager.

The Board heard that the report sought the IJB's endorsement of the Self Evaluation for the review of progress with integration of Health and Social Care which was submitted to the Ministerial Steering Group on 15th May 2019 and to seek approval of the associated action plan for delivering on the proposed improvement actions.

The Board heard that the Action Plan associated with the themes and that after only three years areas of improvement were being identified.

The Board resolved to :-
(1) Endorse the Self Evaluation for the review of progress with integration of Health and Social Care submitted to the Ministerial Steering Group on 15th May 2019.
(2) Approve the associated action plan for delivering on the proposed improvement actions.
(3) Instruct the Chief Officer to provide an update on progress on delivery of the actions in March 2020.

TRANSFORMATION - DECISIONS REQUIRED

12. The Board had before it the report presented by Gail Woodcock, Lead Transformation Manager.

The report sought approval from the IJB to incur expenditure, and for the Board to make Directions to NHS Grampian and Aberdeen City Council, in relation to projects that sit within the Partnership's Transformation Programme. The report also highlights recent financial awards received in respect of TEC pathway and scaling up remote blood pressure monitoring.

The Board heard a summary update on each of the projects which highlighted partnership working and considerations around demand profile and funding.

The Board were assured that performance and review measures were in place.

The Board resolved to :-
(1) Approve the expenditure, as set out in Appendix C, relating to the

Link Working in Custody Suite project, and make the Direction relating to this project as per Appendix B and instructed the Chief Officer to issue this direction to Aberdeen City Council,

(2) Approve the expenditure, as set out in the Business Case at Appendix D relating to Interim Housing, and make the Direction relating to this project as per Appendix E and instructed the Chief Officer to issue this direction to Aberdeen City Council.

(3) Note the award of funding to the city in relation to TEC Pathway and Florence Home Health Monitoring.

GRANITE CITY GOOD FOOD ACTION PLAN

13. The Board had before it the report which was presented by Jenny Gordon, Public Health Dietician.

The report provided the Board with the action plan from the Partnership's Granite City Good Food (GCGF) Steering Group, which has been developed to outline the ACHSCP commitment to the wider GCGF movement in the city.

The Board heard that the plan was developed from previous discussions and that whilst timelines were ambitious, much of the work was either already ongoing or about to commence. The plan had considered the Aberdeen City Council Local Outcome Improvement Plan (ACC LOIP) and a volume of strategy documents from various partners.

The Board were further assured that their earlier observations had been brought back so promptly.

The Board resolved to :-
Note the update report.

NHS GRAMPIAN SERVICES WHICH ARE HOSTED IN ABERDEEN CITY, ABERDEENSHIRE AND MORAY INTEGRATION JOINT BOARDS

14. The Board had before it the report prepared by Sandra Ross, Chief Officer AHSCP which was presented by Adam Coldwells, Chief Officer AsHSCP and Pam Gowan, Chief Officer MHSCI.

The report sought endorsement of a structured framework for the monitoring, performance management and strategic planning of those services delegated to IJBs from NHSG for both strategic planning, and for planning and delivery and recommended that the Board,

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(a)Endorse the approach set out for the monitoring and performance management of delegated services which are hosted by one of the three IJBs on behalf of the other two IJBs
(b) Consider and make any further suggestions to the approach for the Governance arrangements of the Acute Hospital Based Services.
(c) Consider and comment on the frequency which the North East Partnership should meet and instruct officers to prepare a draft role and remit for this meeting.

The Board heard that the three Chief Officers from the integration boards operating in partnership with NHS Grampian had been working collaboratively to gain an understanding of how each operate and intended to develop a different relationship to what had previously existed. As each Board had matured within their own settings, given the volume of shared services and common outcomes, it was identified that as all service provision involved some form of delegation, it was quite appropriate to encourage enhanced partner working within the Boards.

The Board heard that there was an understanding of requirements to ensure assurance against a common matrix and adopt a whole system approach which would not only ensure a better understanding of challenges and opportunities but assist identify areas for improvement in a continuing arena of budget savings and efficiency requirements. The existing cultures and practices were all impact factors on greater collaboration but could be overcome with understanding and inclusion of management, staff and trade unions.

The Board were confident that the approach to be adopted would maintain existing assurances, foster better relationships and ultimately improve service delivery.

The Board resolved to :-
(1) Endorse the approach set out for the monitoring and performance management of delegated services which are hosted by one of the three IJBs on behalf of the other two IJBs and requested that the Senior Leadership Team consider aligning performance reporting to the 12 Principles for Integration
(2) Endorse the approach for the Governance arrangements of the Acute Hospital Based Services and directed that the Senior Leadership Teams work together to produce recommendations for the three IJBs to consider and requested that future reports on hosted services highlight the service alignment to the national indicators and 12 principles of integration, and
(3) Agree the frequency on which the North East Partnership should meet is four times per annum,
(4) Propose that the North East Partnership include Chair, Vice Chair and Chairs of IJB key committees, and

(5) Instruct the Chief Officer (ACHSCP) to prepare a draft role and remit for this meeting in consultation with the Chief Officers for the Aberdeenshire and Moray Health and Social Care Partnerships.

REVIEW OF COMMISSIONED DAY SERVICES

15. The Board had before it the report presented by Anne McKenzie, Lead Commissioner.

The report sought to inform the Board of the outcome of the recent review of day services commissioned by the ACHSCP, to assure the Board of the strategic commissioning approach used to conduct this review and to ask the Board to direct the ACC to maintain the current funding arrangements for day services commissioned by the ACHSCP until March 31st 2020.

The Board heard an overview of the report

The Board resolved to :-
(1) Approve the recommendations made from the review of commissioned day services (section 3.6),
(2) Acknowledged the strategic commissioning approach used to conduct the review,
(3) Approve the request to maintain the current funding arrangements for 2019/20;
(4) Make the Direction, as attached at Appendix C, and instructed the Chief Officer to issue the Direction to Aberdeen City Council;
(5) Note that a report on the strategic commissioning approach will be presented to the IJB in September 2019;
(6) Note that a report on the future provision of day care services will be presented to the IJB in November 2019;

LEARNING DISABILITIES SERVICE REVIEW

16. The Board had before it the report on the Learning Disabilities Service Review.

The report sought approval from the Aberdeen City Integration Joint Board (IJB) for the implementation of a programme to support the further integration of Learning Disability Services in Aberdeen City.

The report recommended that the Board
a) Approve the implementation of the proposed programme, including the award of a call-off contract to the preferred Service Provider under the

HealthTrust Europe (HTE) "Consultancy and Advisory Services Framework Agreement" and the expenditure of £91,575, and;
b) Make the Direction at Appendix A and instructs the Chief Officer to issue the Direction to Aberdeen City Council

The Board heard that the increasing demand on the service had been identified and that it was considered appropriate and beneficial to examine this situation further.

It was agreed that the proposal offered a way forward however the Board heard comment regarding some of the consultation that had taken place involving staff and the trade unions. Assurances were given that there were no concerns but that this exercise had highlighted a learning outcome for improved consultation.

The Board further heard of an amended suggestion to recommendation (a) above to reflect the legally authorised spend.

The Board resolved to :-

(1) Approve the implementation of the proposed programme, including the award of a call-off contract to the preferred Service Provider under the HealthTrust Europe (HTE) "Consultancy and Advisory Services Framework Agreement" and the expenditure of £79,875 plus VAT, plus actual expenses up to £11,700;

(2) Make the Direction at Appendix A and instructed the Chief Officer to issue the Direction to Aberdeen City Council, and;

(3) Instruct the Chief Officer to submit a report to the CCG Committee at the conclusion of the review in two cycles,

(4) Note the staff side/trade union rep comments on consultation processes and

(5) Instruct the Chief Officer to initiate discussion on adoption of a consultation protocol with staff side through the Joint Staff/Trade Union Forum.

CONTRACT AWARD REPORT

17. The Board had before it the report presented by Jean Stewart-Coxon.

This report was heard in private.

The Board resolved to :-
(1) Approve the award of the contract as detailed in Appendix A
(2) Make the Direction, as attached at Appendix B, and instructed the Chief Officer to issue the Direction to Aberdeen City Council

KINGSWELLS CARE HOME

18. The Board had before it the report presented by Alex Stephen, Chief Finance Officer.

This report was heard in private.

The Board resolved to :-
(1) Note the contents of the report and the progress made to date;
(2) Make the direction, as attached at appendix A, and instructed the Chief Officer to submit the Direction to Aberdeen City Council to make the necessary arrangements with the provider to deliver the service.

OPEN SPACE DISCUSSION - INCLUDING CHIEF OFFICER'S UPDATE

19. Whilst this item was heard out with the Board meeting, the matter was discussed during Welcome and Introduction by the Chair.

The Board resolved to :-
Agree to review the provision of this update.

WORKSHOP - HOSTED SERVICES

20. This was held after the Board Meeting.

INTEGRATION JOINT BOARD
11 June 2019

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	A	B	C	D	E	F	G	H	I	J
1	**INTEGRATION JOINT BOARD BUSINESS PLANNER** The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**		**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**03 September 2019**									
4	11.06.2019	IJB Meeting Dates	Council issued meeting dates for 2020, there is a requirement to align IJB, ASP and CCG Committee dates	Reported to this meeting	Derek Jamieson	Chief Officer - Governance	ACC		R	
5	Carried Forward	PCIP Update		Reported to this meeting	G. Woodcock	Transformation Lead	ACHSCP		R	
6	Carried Forward	Strategic Risk RegisterMartin Allan	Bi-Annual - January and June	Not due to be reported to this meeting	Martin Allan	Business Lead	ACHSCP		R	
7	Carried Forward	Transformation Decisions Required		Reported to this meeting	G. Woodcock	Transformation Lead	ACHSCP		R	
8	11.12.2018	Alcohol and Drug Partnership Investment Plan	IJB 11.12.18 Article 16 - The Board requested that an annual report be submitted to the IJB in respect of the Investment Plan. This was scheduled for December meeting.	Reported to this meeting	Karen Gunn	Mental Health Lead	ACHSCP		R	
9	Carried Forward	Action 15 Proposals		Reported to this meeting	Karen Gunn	Mental Health Lead	ACHSCP		R	
10	Standing Item	Annual Report	The purpose of this report is to obtain IJB approval of the partnership's annual performance report for 2018-19 and its agreement that the approved report should be published and also presented to Aberdeen City Council and NHS Grampian for their information.	Reported to this meeting	A. Macleod	Performance Lead	ACHSCP		R	
11	Standing Item	MSG & National Performance Report	Included within Annual Report	Included within Annual Report	A. Macleod	Performance Lead	ACHSCP		R	Included within Annual Report
12		Standards Officer	To inform the IJB of the requirement to nominate a replacement Standards Officer to the Standards Commission, following the retirement of the previous incumbent.	Reported to this meeting	Martin Allan	Business Lead	ACHSCP		R	
13	Carried Forward	Supplementary Work Plan	1.1.The purpose of this report is to present a supplementary work plan for expenditure on social care services, together with associated procurement business cases, for approval.	Reported to this meeting	Jean Stewart Coxon	Procurement	ACC		R	
14	Carried Forward	Heath Visiting		Reported to this meeting in Transformation Report	G. Woodcock	Transformation Lead	ACHSCP		R	
15	Standing Item	Winter Plan	The Aberdeen City Health and Social Care Partnership is required to develop a "Winter Plan" each year to reflect arrangements to support activity over the winter period. The draft Winter Plan before the IJB for period 2019/20 is contained in Appendix One to this report.	Reported to this meeting	Jason Nicol	SOARs Lead	ACHSCP		R	
16		Interim VSH Business Case	Business Case	Reported to this meeting in Transformation Report	G. Woodcock	Transformation Lead	ACHSCP		R	
17		Strategic Commissioning Approach	The report outlines the review of the ACHSCP approach to strategic commissioning. The review is aligned to key recommendations made by the Scottish Government and Audit Scotland and makes recommendations for a robust, systematic approach to Strategic Commissioning within the partnership.	Reported to this meeting	Anne McKenzie	Lead Commissioner	ACHSCP		R	

	A	B	C	D	E	F	G	H	I	J
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**		**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
18	**19 November 2019**									
19	26.03.2019	Localities	IJB 26.03.19 Item 13 - Localities The Board instructed the Chief Officer to report back to the November 2019 meeting of the IJB with a further update on the implementation of the revised localities. Instructed the Chief Officer to discuss opportunities for developing clear, distinct terminology for ACHSCP localities and Community Planning Partnership localities and report back with a recommendation to the IJB.		G.Woodcock	Transformation Lead	ACHSCP			
20	Standing Item	Strategic Risk RegisterMartin Allan	Bi-Annual - January and June		Martin Allan	Business Lead	ACHSCP			
21	Standing Item	Chief Social Work Officer Annual Report			Graham Simpson	Chief Social Worker	ACC			
22	Standing Item	Financial Monitoring Report	Financial Monitoring Report		A.Stephen	Chief Finance Officer				
23	11.06.2019	Review of Commissioned Day Services	IJB 11.06.2019 - (6)Noted that a report on the future provision of day care services will be presented to the IJB in November 2019		Anne McKenzie	Lead Commissioner	ACHSCP			
24	11.06.2019	NHS Grampian Services which are hosted in Aberdeen City, Aberdeenshire and Moray Integration Joint Boards	IJB 11.06.2019 - Instructed the Chief Officer (ACHSCP) to prepare a draft role and remit for this meeting in consultation with the Chief Officers for the Aberdeenshire and Moray Health and Social Care Partnerships.		Sandra Ross	Chief Officer	ACHSCP			
25		Community Mental Health Strategy	Approval of Strategy		Karen Gunn	Mental Health Lead	ACHSCP			
26	11.06.2019	Consultation Protocol with Trade Unions	A consultation protocol was requested with the Trade Unions		Graham Lawther	Communications Lead	ACHSCP			
27	Standing Item	Transformation Decisions Required			G. Woodcock	Transformation Lead	ACHSCP			
28	**21 January 2020**									
29	Standing Item	Transformation Decisions Required			G. Woodcock	Transformation Lead	ACHSCP			
30	Standing Item	Annual Update Autism & LD			Kevin Dawson	Mental Health Lead	ACHSCP			
31	Standing Item	Annual Report on ADP			Karen Gunn	Mental Health Lead	ACHSCP			
32	**11 February 2020**									
33	Standing Item	Annual Budget Papers			Alex Stephen	Chief Finance Officer	ACHSCP			
34	**10 March 2020**									
35	11.12.2018	Autism Strategy and Action Plan	IJB 11.12.18 Article 13 - The Board noted that progress reports on the implementation of the above would be provided annually, with updates to the Clinical Care and Governance Committee in the interim. Suggested April 2020.		Karen Gunn	Mental Health Lead	ACHSCP			

	A	B	C	D	E	F	G	H	I	J
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**		**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
36	26.03.2019	Diet, Activity and Healthy Weight	IJB 26.03.19 Article 17 - The Board instructed the Chief Officer that an annual update on ACHSCP GCGF is presented to the IJB, and (v) Instruct the Chief Officer that the Grampian consultation strategies for Tobacco and Diet, Activity and Healthy Weight are presented to the Board		G. Woodcock	Transformation Lead	ACHSCP			
37	Standing Item	Review of Scheme of Integration	Annual		A. Macleod	Performance Lead	ACHSCP			
38	11.06.2019	MSG Self Evaluation for the Review of progress with Integration of Health and Social Care	IJB 11.06.2019 - Instructed the Chief Officer to provide an update on progress on delivery of the actions in March 2020.			Chief Officer	ACHSCP			
39	Standing Item	Transformation Decisions Required			G. Woodcock	Transformation Lead	ACHSCP			
40	26.03.2019	Health Improvement Fund	IJB 26.03.19 Article 12 - The Board instructed the Chief Officer to bring an annual report relating to the Health Improvement Fund to the IJB in April 2020 and annually thereafter.		G. Woodcock	Transformation Lead	ACHSCP			
41	**24/03/2020 - Not Confirmed**									
42										
43										
44		No reports scheduled at this time.								
45	**23 June 2020**									
46										
47										
48		No reports scheduled at this time.								
49	**08 September 2020**									
50										
51										
52		No reports scheduled at this time.								
53	**01 December 2020**									
54										
55										
56		No reports scheduled at this time.								
57	****/01/2021**									
58		No reports scheduled at this time.								
59	****/02/2021**									
60		No reports scheduled at this time.								
61	****/04/2021**									
62		No reports scheduled at this time.								
63	****/06/2021**									
64		No reports scheduled at this time.								
65	****/09/2021**									
66		No reports scheduled at this time.								

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2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Lead Officer / Business Area**	**ORGANISATION ACHSCP/ACC/NHSG**		**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
67	****/11/2021**									
68		No reports scheduled at this time.								
69	****/01/2022**									
70		No reports scheduled at this time.								
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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	Chief Officer Update
Report Number	HSCP.19.038
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Sandra Ross, Chief Officer
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	Appendix 1 : Chief Officer Update

1. Purpose of the Report

The purpose of this report is to update the IJB on current integration progress, and to consider the future focus of the Chief Officer and Aberdeen City Health & Social Care Partnership in terms of accelerating the pace and scale of integration.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the progress and approve the increased pace and scale of change as set out in appendix 1.

b) Instruct the Chief Officer to liaise with ACC and NHS Grampian regarding resourcing for the Programme of Transformation.

INTEGRATION JOINT BOARD

3. Summary of Key Information

Background

3.1. The integration legislation (the Public Bodies (Joint working) (Scotland) Act 2014) provides a framework for the effective integration of health and social care services It places a duty on Integration Authorities to create a Strategic Plan for the integrated functions and budgets they control.

3.2. During the shadow period of integration and in the first few years of operation, Aberdeen City Integration Joint Board (IJB) has set some solid foundations for progress and has taken the first steps on our journey. With a robust governance framework around the scheme of delegation ACHSCP has been able to progress with the task of integrating health and social care, with clear direction being set by the IJB.

3.3. 2018/19 brought significant changes to the management structure of ACHSCP with three of the four members of the executive team leaving, and only one, the role of Chief Officer, being replaced. This change allowed an opportunity to reflect and consider what was needed at the leadership level within ACHSCP to enable us to take the next steps on our journey.

3.4. At a national level, the policy of integration was reviewed by a number of different organisations. In June 2018 The King's Fund published a paper entitled "Leading across Health and Social Care in Scotland" which summarised the learning experiences of Chief Officers for HSCPs and highlighted the next steps planned. In September 2018, Audit Scotland published a report which highlighted the progress on integration to date across Scotland. In February 2019, the Ministerial Strategic Group (MSG) for Health and Community Care published its Review of Progress with Integration of Health and Social Care. These reports collectively told similar stories; i.e. there is a mixed picture across Scotland, different progress, different pace and different acceptance. They also gave a similar strong narrative on integration i.e. it is here, but it needs an increase in collaboration, pace and reform.

3.5. Alongside these national reports was a backdrop of financial uncertainty, with public bodies under significant financial pressures which could impact on our ability to transform services whilst delivering the savings required.

3.6. The past year has therefore been a challenging environment, where there has been an opportunity to reflect and consider the feedback from the macro- and micro-environment, whilst being mindful of the strong message from partners that more pace is needed.

Progress on Integration to Date

3.7. The IJB's Risk Register proves a useful framework for reviewing progress against a number of the inherited integration initiatives.

3.8. **Risks 1, 2 and 4: insufficient market capability, financial failure and relationships.** A paper is being brought to IJB in September 2019 which outlines the preferred approach to strategic commissioning that we would wish to adopt. It reflects a partnership approach with ACC and aligns the intent of the legislation around co-production and commissioning for outcomes. The approach to commissioning is also familiar to NHS colleagues. If approved by the IJB, ACHSCP in conjunction with the Aberdeen City Council has designed an approach to be adopted during any commissioning activity. This approach will enable us to work better with the market and to shape supply of services in the way required.

3.9. **Risk 3: hosted services.** Hosted services, and those with which IJB has delegated strategic budget planning, have been a difficult nettle to grasp; however, with a collaborative approach, we have pursued a route to address this.

3.10. At an April 2019 seminar, convened to consider the future of the North East Partnership, there was unanimous agreement that there remains value in the three Integration Joint Boards coming together to consider issues for the whole North East of Scotland. The four Chief Executives (NHS Grampian, Aberdeen City Council, Aberdeenshire Council and Moray Council) agreed to develop a North East Group (Officers only) which they would lead. The aim of the group is to develop real top-level leadership to drive forward the change agenda, especially relating to the delegated hospital-based services.

The North East Partnership, of Chairs and Vice Chairs, will focus on hosted services. A paper was brought to IJB in June which agreed this process. Both the CEO group and the Chairs & Vice Chairs group will meet quarterly. The meetings will be evenly staggered between groups, giving some six weeks between them, allowing progressive work / iterative work to be timely between the forums. The dates are currently being arranged.

3.11. **Risks 4, 5 and 6: relationships with partners, service standards and outcomes being achieved and reputational damage.** The Strategic Plan of the IJB is the document where we set out our direction of travel. The refreshed Strategic Plan was approved by the IJB in March 2019. The Leadership Team's 2019/20 objectives have all been set based on achieving the aims, commitments and priorities within the Strategic Plan and there are plans to roll this approach out all the way down to frontline staff establishing a golden thread that links all operational activity to the achievement of our strategic aims and enables staff to identify their contribution to this.

3.12. **Risk 7 & 8: transformation at pace and scale and locality working.** The culture that existed within the senior management team reflected the period of uncertainty those individuals had been through, i.e. the loss of a number of executive team members in quick succession, although it should be noted that during this period the team were ably supported by the Chief Finance Officer (CFO). A paper was brought to IJB in March which outlined the new leadership team structure which is flat and anchors back into the two employer organisations. The leadership structure was designed to support the deliberate shift to prevention described in Appendix 1.

3.13. A paper was approved by IJB on the move from four localities to three and this is progressing with the leadership team currently undertaking preparatory work and discussion on structures to reflect the new localities. Consultation with the current locality leadership groups to understand how we can make progress is also under way.

3.14. The inherited transformation programme has recently been prioritised in line with the refreshed strategic plan and was approved by IJB in March. A list of the programmes along with their links to the strategic plan, medium term financial framework and strategic risk register is set out in the table below.

INTEGRATION JOINT BOARD

Transformation Programme of Work	Links to Strategic Aims & Enablers	Links to Strategic Risk Register*	Links to Medium Term Financial Framework	Comments
Primary Care Improvement Plan	Resilience Personalisation Communities	1, 2, 5, 7, 9	Transformation	Agreed by IJB in July 2018 Specific Funding Source.
Action 15 Plan	Prevention Resilience Personalisation Communities	2, 3, 5, 7, 9	Medicines Management Transformation	Agreed by IJB in July 2018 Specific Funding Source.
Alcohol and Drugs Partnership Plan	Prevention Resilience Personalisation Communities	2, 4, 5, 7, 9	Transformation Medicines Management	Agreed by IJB in December 2018 Part of Community Planning Aberdeen's Local Outcome Improvement Plan. Specific funding source.
Locality Development Transformation Programme	Prevention Resilience Personalisation Communities Connections	1, 2, 4, 7, 8, 9	Transformation Medicines Management Efficiency Savings Service Redesign	Will capture change actions identified in locality plans. Will also include significant cross-cutting projects such as Unscheduled Care and Social Transport.
Digital Transformation Programme	Prevention Resilience Personalisation Communities Connections Digital Transformation Modern & Adaptable Infrastructure	1, 2, 7, 9	Efficiency Savings Transformation Medicines Management Service Redesign	Will support the delivery of the Digital Strategy.
Organisational Development Transformation Programme	Prevention Resilience Personalisation Empowered Staff	6, 7, 8, 9	Service Redesign Transformation	Will support the delivery of the Workforce Plan.

Efficient Resources Transformation Programme	Prevention Resilience Sustainable Finance	1, 2, 7, 9	Efficiency Savings Transformation Service Redesign	Utilising Lean Six Sigma methodology, working deep within teams delivering services to reduce variation and increase efficiency.
Resilient, Included and Supported Outcome Improvement Plan	Prevention Resilience Communities Connections	4, 7, 8	Medicine Management Transformation	Part of Community Planning Aberdeen's Local Outcome Improvement Plan. No specific funding source.

3.15. **Risk 9: recruit workforce to meet current and future needs.** The IJB approved our workforce plan in March 2019 which dovetails into and supports the NHSG and ACC plans.

3.16. **Risk 10: Brexit.** We are linked in with NHSG and ACC to Brexit contingency planning to ensure we are developing plans and contingency to support Scottish Government and key partners' expectations.

3.17. In addition to the various workstreams described in the preceding paragraphs, a Strategic Implementation Dashboard (SID) has been developed which captures all the existing commitments, targets and measures and these have been allocated to each of the five Strategic Aims within the Strategic Plan. giving a delivery dashboard for each. In this way, we will measure the progress of integration and transformation.

3.18. Performance against the aims is reported to both the Audit and Performance Systems and Clinical and Care Governance Committees throughout the year, with the IJB receiving reports on the National and MSG Indicators. It should be noted that while we measure the current indicators the Scottish Government is undertaking work around a framework for integrated services which may bring further metrics on which we are measured; as such the dashboard will be a work in progress.

Future Focus of Integration

3.19. This report highlights that while we have made progress to date, there is a clear message from national bodies that the pace and scale of reform needs to increase across all integration partnerships.

The attached appendix 1 provides the areas of focus for increasing the scale and pace of change required by local and national partners. There are five key programmes which link to our strategic aims:

1. Programme 1 An Approach to Demand Management implemented through a strategic commissioning approach.
2. Programme 2 A deliberate shift to prevention
3. Programme 3 A Data and Digital Programme
4. Programme 4 Conditions for Change
5. Programme 5 Accessible and responsive infrastructure

These programmes are our focus for delivery of the strategic plan. They bring pace and scale to our transformation programme. Together with our approach to strategic commissioning, presented at Board today, as an enabler we will increase our scale and pace of reform.

4. Implications for IJB

4.1. Equalities - It is anticipated that the implementation of this plan will have a neutral to positive impact on the protected characteristics as protected by the Equality Act 2010.

4.2. Fairer Scotland Duty – There are no direct implications to the Fairer Scotland Act arising from this report.

4.3. Financial – There are no direct financial implications arising from this report.

4.4. Workforce – There are no direct workforce implications arising from this report.

4.5. Legal - There are no direct legal implications arising from this report.

4.6. Other - There are no other anticipated implications as a result of this report.

5. Links to ACHSCP Strategic Plan

5.1. **Prevention** Working with our partners to achieve positive health outcomes for people and address the preventable causes of ill-health in our population.

5.2. **Resilience** Supporting people and organisations so they can cope with, and where possible overcome, the health and wellbeing challenges they might face.

5.3. **Personalisation** Ensuring that the right care is provided in the right place and at the right time when people are in need.

5.4. **Connections** Develop meaningful community connections and relationships with people to promote better inclusion, health and wellbeing and to reduce social isolation.

5.5. **Communities** Working with our communities, recognising the valuable role that people have in supporting themselves to stay well and supporting each other when care is needed.

6. Management of Risk

6.1. **Identified risks(s)**

None arising directly from this report

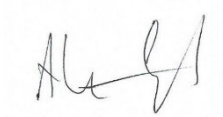
6.2. **Link to risks on strategic or operational risk register:**

All of the risks identified in the strategic risk register.

6.3. **How might the content of this report impact or mitigate these risks:**

The report gives the IJB an update on what has been moved forward over the last year and notifies the IJB of priority areas for the Chief Officer over the year ahead.

INTEGRATION JOINT BOARD

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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APPENDIX 1

Introduction

The covering report sets out the progress on the inherited transformation programme.

This paper sets out the planned reform programme for the duration of the current Strategic Plan, while also laying foundations for the next strategic planning period.

Each of these programmes of work detailed within this report links back into the five strategic aims set out in the Strategic Plan and contributes to achieving their outcomes.

The report which is presented to the Integration Joint Board today on our proposed approach to strategic commissioning is an enabler to help us progress significant parts of our programme of reform.

Having recently agreed the new leadership structure, there is sufficient capacity and capability within the leadership team to drive the delivery of this programme forward. Each of the programmes will have an identified Leadership Team lead and further specialist support will be accessed from across the partnership.

Scope of our Programme of transformation

The IJB has responsibility for planning and delivering community-based health and social care services under the integration scheme as well as planning and delivering Grampian-wide hosted services. In addition, all IJBs are responsible for the strategic planning for hospital-based services and it is in this area which integration authorities are seen to have made the least progress.

Demand across all these areas of service provision continues to grow and we continue to see a mixed picture in terms of outcomes. This paper sets out proposals for how to scale up plans for reforming services as well as for increasing the pace of these reforms across the three areas of services identified above.

Five programmes of transformation are being proposed, as summarised in the table. If the programme is approved, all programmes, projects and timelines will be refined further. It is anticipated that the programme will be aligned to the three-year Strategic Plan 2019/22.

Programme 1 - An approach to demand management implemented through a strategic commissioning approach	Projects and Focus
Programme 1a **Reduction in unscheduled care in Aberdeen Royal Infirmary (ARI)**	Strategic Grampian-wide review of care of the elderly, respiratory care, specialist older adults' rehabilitation and

	emergency care. Focus on demand analysis of the impact on emergency department from specific conditions: • Older people in relation to falls • Multiple admissions • Respiratory conditions Specific projects: a) Work with providers to increase technology for prevention of falls b) Scale up MDT/Silver City to emulate 'virtual ward' concept. c) Increase interim beds capacity d) Respiratory conditions
Programme 1b **Reduction in unscheduled care in Royal Cornhill Hospital (RCH)**	a) Strategic review b) Action 15 projects c) Alcohol and drug projects (ADP)
Programme 1c **Reduction in demand in hosted services**	Review of hosted services
Programme 1d **Improving the delivery of value demand within community-based services**	a) Stepped care approach b) Immunisation uptakes c) PCIP projects
Programme 1e **A single point of access for people requiring health & social care services**	a) Implement Access 1st

Programme 2 - A deliberate shift to prevention	Projects and Focus
Programme 2a	a) Promoting healthy, independent living

Long-term prevention plans to be brought to Board.	b) Adopt an assets-based approach c) Connect communities in order to build resilience
Programme 2b **Refreshed locality plans to be brought to Board**	

Programme 3 - A data and digital programme	Projects and Focus
Programme 3a **Digitisation of back office processes**	A Data & Digital Strategy a) Health Visiting project
Programme 3b **Use of technology to deliver change in frontline service delivery**	a) Working with providers to increase use of technology, such as consider technology solutions reducing the need for sleepover and waking night support b) 'Attend anywhere' scale-up to promote access to GP from community, care homes and people's homes c) Florence system for blood pressure monitoring by the individual at home, sharing results with the GP

Programme 4 – Conditions for change	Projects and Focus

Programme 4a **Cultural change**	a) Lean Six Sigma b) Workforce Plan
Programme 4b **Digital programme for staff**	a) Roll-out of technology to support staff mobility and flexibility b) Roll-out of Office 365 to support further collaboration
Programme 4c **Estates plan**	a) Estate plan to support co-location of staff with Community Planning Partners (CPP) and enhanced connectivity with our communities

Programme 5 - Accessible and responsive infrastructure	Projects and Focus
Programme 5 a **Place shaping and place planning**	a) Market position statement b) Infrastructure plan

An overview of each programme is provided below, followed by a drill-down into one of the programmes.

PROGRAMME 1: An Approach to Demand Management, implemented through strategic commissioning

As described in the strategic commissioning report included on the board agenda for its September meeting, to make further progress at pace and scale we need to understand our demand by using a demand methodology to support the redesign of services.

A community planning partnership approach is being taken to develop a methodology for analysing demand that will enable all partners, including the IJB, to understand the type of demand which is being responded to across the system from the view of our citizens. By understanding the flow of demand through the perspective of our citizens we can understand how services are used and provided.

The following classification of demand is being proposed:

1. **Value demand** - These are the demands we want our citizens to place on the system. They should reflect the reasons for our being. Reflecting the Scottish

Government's own recommendations, preventing demand through earlier intervention is a positive step to take.

2. **Negative demand** - Turning off negative demand has an immediate impact on our capacity. We can further sub-divide negative demand:

    a. Failure demand - demand from service failure or poor design.
    b. Avoidable demand - demand arising from behaviours that can be influenced or changed.
    c. Excess demand - providing a higher level of services than is needed.
    d. Co-dependant demand - demand unintentionally reinforced and entrenched by service dependence.

This classification of demand can be used to produce a detailed analysis of demand across all commissioned services.

To enable us to then consider the design of services, an appropriate response is required to each category of demand. This will cover short, medium and long-term responses. In broad terms removing failure demand and avoidable demand is likely to deliver short-term wins. Redesigning services around citizens could remove excess demand and co-dependant demand will bring medium-term successes. Ultimately, we must plan a more deliberate shift to a preventative focus, as advocated by the Christie Commission, in order to in the longer term prevent non-value demand from arising.

The opportunity, through a strategic commissioning approach, is to design services differently and, in doing so, strengthen the resilience of the population and reduce demand on services. This creates a shift away from negative demand to value demand. If the IJB approves the strategic approach outlined in the Strategic Commissioning report, this will provide the stepping-stone on which we begin the next stage of our journey in terms of shaping the services provided externally by the market and those provided by our public partners.

PROGRAMME 2: A Long-term Approach to Prevention

The Christie Commission advocated a deliberate shift to prevention and the leadership model for the IJB has been designed to support a more deliberate shift. The health improvement teams within public health, and teams within the council, are all attempting to prevent demand. This programme presents us with the opportunity to identify some long-term programmes as a result of our growing understanding of the demand being absorbed within the health and social care system, to enable the shift. Some of these programmes can be undertaken on a city-wide, whole-population basis. Other programmes will warrant a very targeted approach in terms of population groups and/or geographical areas. The intention is to develop these long-term programmes with partners and to submit them to the board in due course. These prevention programmes will focus on:

- Promoting healthy, independent living
- Adopting an assets-based approach
- Connecting communities in order to build resilience.

The shift to three localities has provided an opportunity to refresh the locality plans in conjunction with the CPP and we will take this opportunity to ensure a focus on the prevention agenda. We will bring refreshed locality plans to the Board which will focus on the early intervention and prevention agenda**.**

PROGRAMME 3: Our Data & Digital Programme

Our Digital Lead post is still in the process of recruitment and once complete will focus on designing a digital and data strategy to bring to the IJB for approval. It will move us through a digital maturity journey, moving us from traditional delivery to a transformational delivery model (see Fig1 on page 8), whilst ensuring alignment with partners at a local and national level.

The digital and data strategy will set out a plan to build on our understanding of people by gathering and analysing data about citizens and bring together citizen data, including their perceptions and satisfaction, to develop insight and a multi-agency view of demand. The IJB will target services based on a detailed understanding of need, often in partnership with other public sector organisations; therefore, we will continue to work with partners to integrate and analyse data that enables us to target service delivery.

This will also make it easier to do our jobs by equipping our workforce with technology that allows flexibility and agility to respond to service users' needs, giving citizens better choice in how they get information and access services, and will ensure that we share information and use data to make better decisions.

Therefore we need to create a deliberate programme which will focus on the digital journey from traditional to transformational, (Programme 3a) which is focused on the first three steps (see Fig 1) and a separate programme (Programme 3b) which focuses on steps four to five (see Fig 1).

Data is critical to both programmes' success as well as overall to underpin our demand approach.

Programme 3a – We are focused on understanding how technology can support service delivery, but we recognise that we also must understand what processes we need, and which can be streamlined or automated. Accessibility to systems and information in the field is key to help make sure that our staff are spending as much time with service users as possible, without the restriction of having to work between offices and services. Further automation of routine administration and tasks can be achieved with digital automation to free up workforce capacity. Therefore, another key aim of our digital and data strategy will be to ensure that our systems help our workforce and customers to transact in a digital world.

Projects:

a) We have developed an example which demonstrates how we plan to progress through steps 1- 3 in the digital journey, increasing staff capacity as a result of moving from being paper-based to being able to be automated and agile. A test of change is proposed within Health Visiting in which we support frontline staff to be engaged and own the opportunities presented through digitalisation. This team has been on the operational risk register for some time due to major recruitment challenges within the city. This redesign will see the implementation of an automated scheduling and caseload system, facilitated by mobile technology. It will reduce workload, which will have a positive impact on staff wellbeing and retention and the delivery of services. There is a paper to the Board today to approve progression of funding for this project, with the aim of it becoming operational by November 2019.

Programme 3b – The current pace of technology within the health and social care sector is significant, and there is opportunity and need for us to embrace and progress this agenda.

We aim to work with partners to design services which maximise the use of technology to promote independent living and independent management of conditions and to reduce the co-dependency demand we have created as a result of the service delivery methods we have adopted. This will focus on the use of technology-enabled care, design of infrastructure and self-management.

Our digital and data strategy will also ensure effective use of data and provide a single view of the people accessing services. The value of data will help ensure that we have the right information and processes to make wise choices in the way that we run our services and budgets for today and the future. Using data-driven technology to transform services will also help get the most out of data, basing tough choices on the strong analysis.

As we continue to see rising demand for many services, the effective use of data and business intelligence (BI) provides an opportunity to predict and model services in advance to intervene earlier and ultimately prevent harm. The ability to bring together data from different systems will ensure that managers have the right information available to them to make decisions both now and for the future. Furthermore, the ability to share a single view of citizens can help connect services to the changes in the communities and use BI to manage the delivery of our commitments to them.

Data and technology are being revolutionised through the development of data science, predictive analytics, data mining and cognitive processes such as machine learning and AI. Developing uses of these techniques offers opportunities to redesign public service built around the needs of local people

Projects:

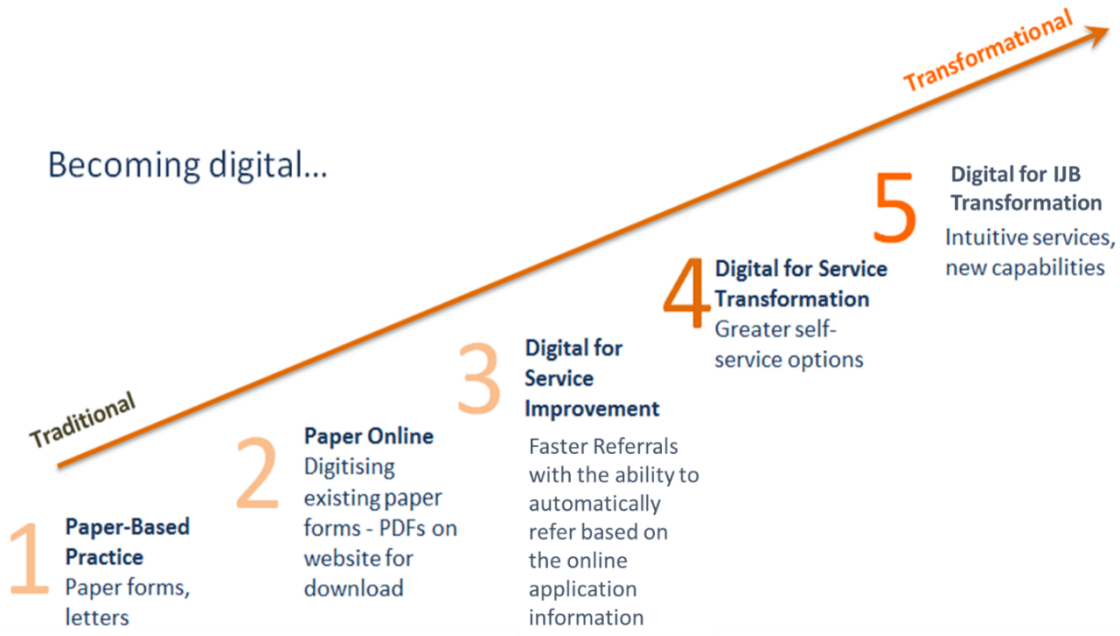
a) We will work with providers to maximise the use of technology solutions in design and delivery of services; in this way we can look to deliver sustainable services in a more robust marketplace. An example would be to understand

how we can apply the learning from the Dumfries and Galloway test of change in bringing a technology solution to reduce the need for sleepover and waking night support.

b) We will explore how we can replicate the example of good practice from Perth & Kinross to bring 'attend anywhere' into our care homes. The expected benefits are that this will bring about a less disruptive method of securing specialist healthcare and support the planning process for individuals, reducing their personal need to travel and easing associated pressures on care homes.

c) The Florence SMS system allows people at home to record and monitor their blood pressure and send the results direct to the GP. This is an example of best practice used in South Lanarkshire with positive outcomes for service users and GPs. We await information governance passing through Scottish Government to commence this locally at both scale and pace.

Fig 1



Programme 4: Conditions for Change

We can describe our key conditions for change around:

- Creating the right culture of collaboration and innovation and ownership of change

- Providing our workforce with the digital tools to enable them to work flexibly, efficiently and effectively, particularly in terms of access to data

- Building relationships across our partnership workforce and with communities through the co- location of staff together and in community settings in order to be community facing and for opportunities to integrate services to be identified by staff themselves.

There is a need to support frontline staff in developing ownership, supporting positive risk-taking and feeling empowered to make changes. This cultural shift will require a robust implementation of our workforce plan. Two examples of current work give a confidence that staff are starting to feel empowered to implement change:

- There has been progress emerging from the work we have commenced through the application of Lean Six Sigma performance improvement techniques. We are working through the first tranche of projects. A prioritisation process is under way for the second phase, which will identify the areas of focus. This is an outcome-based approach which will ensure we focus on projects linked to our programme of transformation.
- An example of tranche 1: we have, through process redesign, been able to improve the patient-facing time of a group of District and Community Nurses by 119%. We continue to work with teams on others, such as social care financial assessments and wheelchair access, mindful that tranche 1 is the learning phase.

By using this approach, we are not looking to reduce or cut the current workforce, but to balance the demands of their role with the resources we have and those we anticipate in the future.

In developing a culture of collaboration, a lot of investment is under way in system leadership across the partnership. The expansion of mindsets is critical at this juncture, as system thinking helps us to understand that the boundaries of professionals and organisations are not the priority, but our shared priority is improved outcomes.

Increasing staff's use of mobile technology will enable a physical flexibility in terms of staff working and use of tools like Office 365 enables more collaboration. Therefore, the digital programme (Programme 3) will need to have a third element which focuses on digital technology to enable staff mobility and collaboration. It is anticipated that we will have a roll-out approach to the use of mobile technology and in line with the programmes of ACC and NHS Grampian, a roll-out of Office 365.

An Estates plan will allow us to work with NHS Grampian and ACC partners to understand what is required to facilitate the co-location of staff across the system, with a particular focus on the co-location within our locality areas in order to ensure staff are community facing. A plan is under development and will be brought to the Board in due course. We anticipate co-location opportunities being prioritised within our locality areas first.

Programme 5: Accessible and responsive infrastructure

There is a need to plan for the future and consider now what services will be provided and from where. Starting with our data and working with our partners we can look to begin to design what we need, maximising our use of place. For example, current data indicates an increasing number of young adults with complex care needs requiring care. We have a requirement to look at out-of-area placements and at accommodation solutions for older people with dementia, complex physical needs and those with a learning disability.

If one of the ambitions of integration is to shift the balance of care by ensuring that people live their full lives in our communities, even when experiencing changes in their health, then the provision of private and social housing will have to change in the city.

In addition to influencing the design of private and social housing (of which the council is a significant provider in the city) , we also need to influence the market in terms of the design of care and support provision as well as the design of any community facilities which the partnership views as appropriate. Early success has been achieved in the city through the development of community hubs as indicated in the Primary Care Improvement plan (PCIP). The community hubs can be a focus for co-location, supporting enhanced collaboration across Community Planning Partners whilst also ensuring we are community facing. Evidence from our current Healthy Hoose project can support scale-up in this area.

The city is experiencing a significant investment in the early years and the schools estate and this estate could be used to support a deliberate inter-generational approach within our communities.

We will produce an infrastructure plan that will lay out the requirements for future service delivery based on design to reduce demand across public services. This will be aligned to partners and inform our market position statement. This infrastructure plan will be brought to Board in March 2020.

DRILL-DOWN INTO PROGRAMME 1

The following part of the report highlights the areas we are working on or will focus our immediate attention on.

PROGRAMME 1: OUR APPROACH TO DEMAND MANAGEMENT, IMPLEMENTED THROUGH STRATEGIC COMMISSIONING

As we progress with the redesign of services, it is critical that we ensure that there are clear pathways established for our users of services, between primary care and locality teams, intermediate care, specialist services and acute care so that people benefit from access to the right care, from the right person, at the right time as their needs change. Our approach to commissioning will facilitate a co-produced approach across the system to bring a more cohesive approach.

Hospital-Based Services:

As advised in the review of progress to date, work has begun on the strategic planning for hospital-based services. It is essential that planning for hospital-based services is moved forward on a Grampian-wide basis in order that NHS Grampian can manage the redesign of acute services, whilst of course requiring to meet the needs of three geographical areas.

The following are services provided within hospitals for which the three IJBs have strategic planning responsibilities, but which continue to be operationally managed by NHS Grampian:

- Accident and Emergency Services provided in a hospital (ED)
- Inpatient hospital services relating to general medicine, geriatric medicine (care of the elderly), rehabilitation medicine (SOARS), respiratory medicine and psychiatry of learning disability; and
- Palliative care services provided in a hospital.

Strategic plans are at consultation stage for Mental Health & Learning Disability and for Palliative and End-of-Life Care. A plan for Care of the Elderly is due in September. These plans will be followed by ones for Respiratory Care, Specialist Older Adult Rehabilitation Services (SOARs) and for the ED.

These Grampian-wide strategic plans will outline the high-level ambitions of each of the partners, set the direction of travel for more efficient use of resources across the system, and assist with shifting the balance of care towards community settings.

The North East Chief Officer group will provide oversight and a critical friend approach, building relationships, and encouraging collaborative working and engagement with our partners to seek full agreement for each plan prior to getting approval from each IJB.

The North East Partnership of IJB Chairs and Vice Chairs will have oversight and scrutiny of the hosted services, with each HSCP sharing performance reports and updates. This forum will undertake a review and critique of current delivery models and agree new models moving forward.

Programme 1A: Reduction in Unscheduled Care to ARI

An outcome of the strategic plans for palliative and end-of-life care, plans for care of the elderly, respiratory care, SOAR and emergency departments will all contribute to the reduction in unscheduled care and start to shift aspects of negative demand.

Whilst we develop the strategic plan for the Emergency Department, we will continue to try and remove the avoidable demand in terms of admission. We have in the past made significant progress on delayed discharges, but as demographics shift, we have

seen an increase in demand and a limited ability to increase capacity due to bed base and market capability. If we continue the current trajectory we will return to the days of high numbers of delayed discharges. Even though we have redesigned part of the system, now we need to consider the other parts of that whole system.

In the short term, we are working with NHS Grampian's Health Intelligence and Aberdeen City Council's Business Intelligence to focus on three types of emergency admission to ED:

- older people in relation to falls
- multiple admissions and
- respiratory conditions.

Our ambition is that we will use geographical information systems (GIS) mapping, population needs assessment, health data and hospital admission data to drill into areas across the city where these areas present the largest admission rates. We can then investigate causes and work with the community and all partners to redesign the system and shift that demand from hospital to the community.

Projects:

a) We are working with local providers to explore the impact of wearable and monitoring technology that has reduced falls significantly across supported accommodation.
b) We will review the examples of good practice being undertaken by Aberdeenshire and East Kilbride and understand how we can implement the multidisciplinary approach to preventing admissions of those most at risk; we will achieve this by building on our own version, 'silver city', and the work being done around multi-disciplinary team (MDT) meetings which both focus on those with increasing needs and risk of admission, increasing services from the MDT as required.
c) We are working to increase and scale up the interim bed availability across the city, with a paper being presented at Board today; being mindful of the need to promote independence, we are working with providers, housing and occupational therapy colleagues to invest in current voids within sheltered and very sheltered complexes to increase capacity. This model will initially assist with surge capacity.
d) We will build on the positive outcomes achieved by the respiratory bundle project, in which we are working pan-Grampian on the same approach to chronic obstructive airway disease regarding prevention of exacerbation information and pulmonary rehabilitation.

PROGRAMM 1B: Reduction in Unscheduled Care at Royal Cornhill Hospital

The advent of the Grampian-wide strategic plan will facilitate the introduction of a transformation steering group which will bring a focal point to understand the collective

impact of reform. Coupled with the commissioning approach, this will assist in redesigning services across all four tiers of service delivery.

Projects:

a) The continued work through Action 15 will bring both short-term and medium-term gains through our demand methodology. This will bring a reduction in direct access to more specialist services (tier 3) and hospital-based (tier 4) which will increase their capacity and ultimately reduce waiting times.

   - A report is being presented at Board today which seeks approval for further roles to support tiers 1 &2 within primary care. This project will see the scaling up of the Primary Care Psychological Therapy service which has been in place in Aberdeen since 2018. The service provides clinically effective evidence-based psychological treatment for those suffering from mild to moderate common mental health issues such as anxiety disorders and depression. This increase in support at primary care level should see a reduction in referrals to tier 3, reducing waiting times and bringing more personalised support (right care, right time, right place)

   - A report is being taken to the Board today to provide an alternative to the existing specialist pathway for those individuals who are experiencing mental health distress and who come to the attention of Police Scotland and the Custody Suite at Kittybrewster or who present to the Accident and Emergency Department at ARI. The custody suites are hosted by Aberdeenshire and used by offenders and patients who are mainly from Aberdeen/Aberdeenshire. The A&E Department will see patients from both authority areas. Whilst this project is primarily focused on enhancing the current pathway by providing a lower tiered level of response, this alternative model will contribute to a much-needed cultural change and begin to encourage citizens to develop the knowledge and skills required to enhance their personal resilience.

b) We will continue to support the themed approach taken by Alcohol and Drugs Partnership (ADP) which supports range of action across the ADP, the Health and Social Care Partnership and Community Planning Partnership to work together to tackle drug and alcohol-related issues. It supports whole-system approaches and seeks to include and involve localities, the public, service users and those with lived experience of recovery.

   1. Whole-family approach
   2. Reduce harm, morbidity and mortality
   3. Service improvement
   4. Supporting recovery
   5. Intelligence-led
   6. Locality partnerships

Programme 1C: Reduction in demand to hosted services

Hosted services will be reviewed and redesigned through the North East Partnership.

This will enable us to use a pan-Grampian approach to redesign, considering demand management and strategic commissioning as focus and enabling agents. By utilising this methodology, we can work through hosted services and current and desired outcomes.

SERVICE	CURRENT HOST
Sexual health services	Aberdeen City
Woodend assessment of the elderly	Aberdeen City
Woodend rehabilitation services (including Stroke, Rehab, Neuro rehab, Horizons, Craig Court and MARS)	Aberdeen City
Marie Curie nursing	Aberdeenshire
Heart failure service	Aberdeenshire
Continence service	Aberdeenshire
Diabetes MCN (including retinal screening)	Aberdeenshire
Chronic oedema service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire
Out of Hours GO cover (G-Meds)	Moray

Programme 1D: Shift demand to value demand in community-based services

a) We aim to deliver sustainable services for community-based urgent unscheduled care, comprising advanced practitioners and care staff who are available to respond rapidly to changing needs, offering people home-based alternatives to acute hospital admission. We are evolving our acute care at home model into a stepped care approach; this will continue to develop and scale up. This model now links in existing services such as out of hours district nursing and social care responder service; in addition, we are providing focused support to care homes. This approach allows prevention of admission through

community (GP, out of hours) and also referral directly from ED to prevent admission.

b) We are working on improving our uptake of immunisations across the population which can contribute to reducing negative demand in areas such as flu and immunisations programmes for young people.

c) We will continue to work through projects which are supported through the PCIP which shift the balance from GPs to a more multidisciplinary and system-wide approach. In this way we can promote early intervention and prevention strategies to move towards value demand.

Programme 1E

Across the system we have multiple points of access and referral points for both people who use services and professionals. There is a need to streamline the process and improve access for all.

People who access services often report that it is difficult to know who to go to, where to go and when. Individuals can be passed from one service to another, causing frustration, delays and often repetition of their story, personal information and time. This can cause delays in accessing vital services, or individuals may get frustrated and give up, failing to access information or services which could assist them.

A single access point for health and social care would allow a place where people contact services, through various mediums, and access information either by self-serve or a triage system which can direct and support them to appropriate services.

This approach would facilitate an increased awareness of where to go to, and the triage system would ensure people are guided through the complex system in a more timely and accessible way. It builds on the theory underpinning the link workers within GP practices, where we can support people to access the right services, at the right place and the right time.

This will bring efficiency in resources across community partners, preventing duplication of effort, reduce complex referral systems and reduce waiting times.

Project:

a) We are looking at the model of Inverclyde (Access 1st), and other national projects which are already established, to facilitate this ambition. The impact and longevity of examples of best practice will allow us to move at pace and scale as we adopt what others have progressed. We can adapt them to suit our local needs for the city and can achieve this operationally to achieve the pace we require.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	Strategic Commissioning
Report Number	HSCP.19.043
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Sandra Ross, Chief Officer
Consultation Checklist Completed	Yes
Directions Required	*N/A*
Appendices	Appendix 1 approach to strategic commissioning Appendix 2 progress to date and next steps Appendix 3 current versus future approach

1. Purpose of the Report

1.1 The report outlines the activities that have been taken to embed a strategic commissioning approach across the Aberdeen City Health and Social Partnership (ACHSCP) in order to enhance integrated service provision and deliver the ACHSCP's commissioning intentions. It also describes and seeks the Integration Joint Board's (IJB) agreement of a joint commissioning approach to be taken by both the IJB and Aberdeen City Council (ACC).

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the joint commissioning approach described in Appendix 1, noting that the approach has been submitted for approval by Aberdeen City Council's Strategic Commissioning Committee,

b) Note the progress in the development and implementation of the strategic approach as described in Appendix 2 to date and approve the establishment of a Strategic Commissioning Board and framework for decision making,

c) Instruct the Chief Officer to create a market position statement and to provide a progress report on the document to the Board in December 2019,

d) Approve the application of the strategic commissioning approach for discharging the IJB's responsibilities for the planning of acute-based services,

e) Notes the key milestones to be achieved within strategic commissioning over the next year, and approximate timescales, described in Appendix 2, including the delivery of a report against a three-year strategic commissioning plan to the IJB in November 2019,

f) Instruct the Chief Officer to deliver a progress report to the IJB against these key milestones in March 2020.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. The ACHSCP refreshed Strategic Plan was approved in March 2019. The plan was developed with reference to a number of existing delivery, partner and enabling plans, most notably NHS Grampian's Clinical Strategy and the Local Outcome Improvement Plan (LOIP), where commitments, targets and measures already existed.

3.2. The Strategic Plan will direct the ACHSCP commissioning activities and in future, a commissioning plan for the duration of the strategic plan will be produced.

3.3. Since the Christie Report in 2011, Audit Scotland and the Scottish Government have produced various documents and guidance which are explicit on the direction of travel for public services across Scotland. These documents collectively bring a narrative of the increased pressure now and in the future on public services in terms of resources and demand. They highlight that to ensure that we have services that are fit for the future we need to redesign, reform and collaborate, not only across the public sector but wider community planning partners and the external providers which support them.

3.4. The Scottish Government, describing strategic commissioning, suggested that its importance to the integration of health and social care cannot be understated: "We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience." Strategic commissioning requires trusting relationships and strong system leadership with a shared vision, values and priorities. This level of commissioning is inclusive of all partners and by adopting this approach across the range of services we can deliver the impact required to start to meet the pressures faced across all public services.

3.5. The Public Bodies (Joint Working) (Scotland) Act 2014 describes the Integration Joint Board as having responsibility for strategic planning of services within NHS Acute services; the role of joint commissioning to deliver on this strategic commissioning role is implicit. This is a new approach and new mature relationships will need to be fostered to progress with the reform

to ensure the key purpose of integration is achieved, improving the wellbeing of service users through applying the principles of integration. The recommendations (3(iv) 3(v)) from the recent MSG report which reviewed the progress of integration supports this approach.

3.6. The ACHSCP in conjunction with Aberdeen City Council has designed an approach to be adopted during any commissioning activity. This approach reflects the recommendations from Audit Scotland in November 2018 which identifies that it is not possible for one organisation to address the scope and pace of change that is required and that partners need to work together to bring the change that is required to sustain services.

3.7. The money for functions that are provided by large hospitals but are delegated to the IJBs, such as unplanned care, is referred to as the 'set-aside' budget. Instead of paying the monies to IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. In line with Scottish Government guidance, NHS Grampian continues to manage the set-aside as part of their own resources. To date the set-aside aspect of the Act is not being fully implemented. Our approach to strategic commissioning is a methodology which can help progress this shift, as described in Appendix 1 (accompanying report).

3.8. This paper is bringing a clarity and explicit approach to what is intended in legislation around commissioning of all services. We have started this process by using a co-production approach through the development of the Grampian- wide strategic plans which are currently out for consultation, mental health & learning disability, palliative care and older people. Commissioning of services is not new to NHS colleagues and it is important in this context it is not confused with procurement, which is a different process, as highlighted in appendix 1 of this paper.

3.9. Clearly, the adoption of a commissioning approach by the IJB to planning the design and delivery of acute services represents a significant change and it will be essential that the IJB adopts this approach in partnership with the Acute sector. Therefore, much consideration will be given to the membership of the proposed strategic commissioning board to ensure the appropriate involvement of the acute sector and advice will be sought from all the relevant

acute clinical and professional leads and structures to ensure the full engagement of acute services in the development of the approach.

3.10. Our commissioning approach will involve service providers and the wider public. We will co-design and co-produce future service delivery and in this way ensure that we are promoting healthy and independent living, improving outcomes and that services are accessible.

3.11. The IJB Strategic Plan, which is aligned locally to the Grampian Clinical Strategy and the Local Outcome Improvement Plan (LOIP), sets out of five focus areas of resilience, communities, connections, personalisation and prevention. As we develop our delivery plans and Grampian-wide strategic plans we will need to redesign and reform delivery of services. By taking this commissioning approach, we will ensure that we apply the same outcome-focused, inclusive and co-produced approach to this reform. Within the Board agenda, the Chief Officer's report sets out the intended programme of transformation and Board members will see that the commissioning approach outlined in this report is identified as a key part of the transformation programme. The report also makes reference to future transformational activity making an intentional shift to a preventative approach, increasing the value demand placed upon services. Strategic commissioning will play a valuable role in this transformational shift through appraisal of population demand and the most effective means of delivery.

3.12. Appendix 1 (attached) sets out the approach to strategic commissioning.

3.13. Appendix 2 (attached) sets out the detail of progress to date and next steps. In summary, our key next steps will involve:

- the formation of a Strategic Commissioning Board
- the creation of a three-year strategic commissioning plan
- the development of a market position statement.

3.14. Appendix 3 sets out the key differences from our previous approach to contracts-driven commissioning and our future strategic commissioning approach.

INTEGRATION JOINT BOARD

4. Implications for IJB

4.1 Equalities - the recommended process will promote consideration of equality diversity.

4.2 Fairer Scotland Duty – there are no implications.

4.3 Financial – the recommended process requires consideration of available funds and consideration of best value through redesign.

4.4 Workforce – the process offers the workforce a framework within which to work.

4.5 Legal - there are no direct legal implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1 The Integration Joint Board's (IJB) Strategic Plan (2019 – 2022) states that principled commissioning will play an important role in achieving the ambitions of the plan. It states that strategic commissioning will:

- be undertaken for outcomes
- be based upon evidence and insight
- be considerate of sustainability from the start
- adopt a system-wide approach
- promote solutions that enable prevention through early intervention
- balance innovation and risk
- be based upon sound methodology and appraisal of options
- be co-designed and co-produced with partners and members of the public.

6. Management of Risk

6.1 Risk 1:
Description of Risk: There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as

outlined in the integration scheme. This includes commissioned services and general medical services.

6.2 Risk 3:
There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

6.3 Risk 4:
There is a risk that relationship arrangements between the IJB and its partner organisations (Aberdeen City Council & NHS Grampian) are not managed to maximise the full potential of integrated and collaborative working. This risk covers the arrangements between partner organisations in areas such as governance; corporate service; and performance.

6.4 Risk 7:
Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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APPENDIX 1

A JOINT STRATEGIC COMMISSIONING APPROACH BY ABERDEEN CITY COUNCIL AND ABERDEEN INTEGRATION JOINT BOARD

CONTENTS

SECTION 1: WHAT IS STRATEGIC COMMISSIONING?

What do we mean by strategic commissioning?

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcome, considering options, planning the nature, range[1] and quality of future services and working in partnership to put these in place.

As per the Scottish Governments own guidance[2], the focus of strategic commissioning should be less about how things are done currently and more about how they should be done in the future. The real added value is to enable the shift of resources to deliver commissioning intentions within an outcome-based performance framework.

Most models of commissioning emphasise a cyclical nature, with strategic commissioning providing the context for procurement and contracting. The cycle is sequential and with each element of equal importance. The cyclical nature of 'analyse, plan, do and review' brings strategic plans to life. Outcomes for people must be at the centre of a commissioning model.

Strategic commissioning is crucially about establishing a mature relationship between different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population. Every partner has a role to play in the strategic commissioning process and that is why it is important that local arrangements promote mature relationships and constructive dialogue.

What do we mean by joint commissioning?

The creation of integration authorities, as a result of the Public Bodies (Joint Working (Scotland) Act 2014, now requires us to undertake joint commissioning between the Council and NHS Grampian. Joint commissioning is a complex strategic activity combining traditional disciplines of strategic planning, service design, procurement, internal service planning and performance management, and applying these disciplines in a new multiagency environment.

Systems leadership is often referred to, but it is a term with many meanings. In the context of joint commissioning, system leadership means both shared and collective leadership between the Council and the NHS, but also including providers and other partners, such as the voluntary and community sectors. It needs to be inclusive, actively seeking the views of people and communities, and of frontline staff. Like all good leadership, it requires clear accountability, with leaders holding each other to account, as well as being held to account by local people.

[1] 1oint Strategic Commissioning – A Definition: Strategic commissioning steering group June 2012

[2] Strategic Commissioning Plans for Guidance

As policy places greater emphasis on individual choice and control through self-directed support and person-centred care, the role of public agencies as facilitators of service development, rather than only as direct purchasers or suppliers, will also become more important.

People involved in commissioning may already have experience in some aspects of the overall cycle, and with particular service areas, but they now need to draw on new models, new relationships and new skills to enable joint strategic commissioning.

Where money comes from will no longer be of consequence to the service user, customer or patient. What will matter instead will be the extent to which partnerships achieve the maximum possible benefit for service users and patients, together and against the backdrop of shared outcomes and an integrated budget.

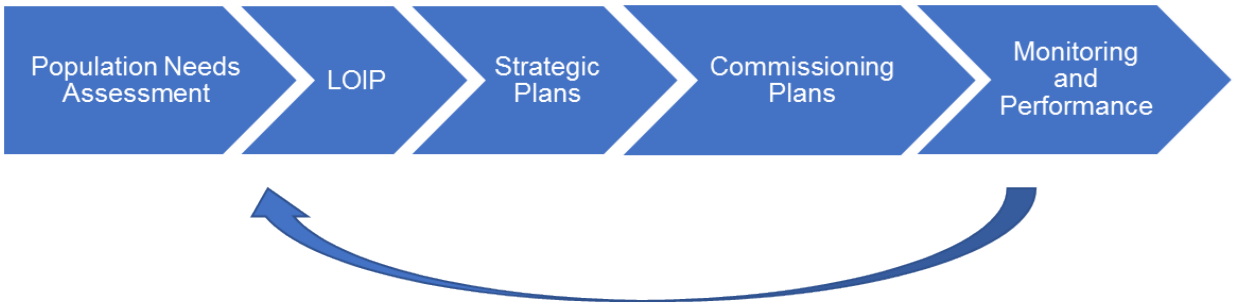
By strengthening our system-wide approach and collaboration we will start to better understand the impact we can make, where these impacts can make a significant difference and what the planned change should be to shape future demand. This understanding and analysis can facilitate a redesign and commissioning of future services to meet the current and predicted population needs. A radical reform in the way we currently look at and deliver services is required, with a staged and managed collective journey to reduce silos and bring collaboration and system thinking to our approach.

SECTION 2: STRATEGIC COMMISSIONING ELEMENTS

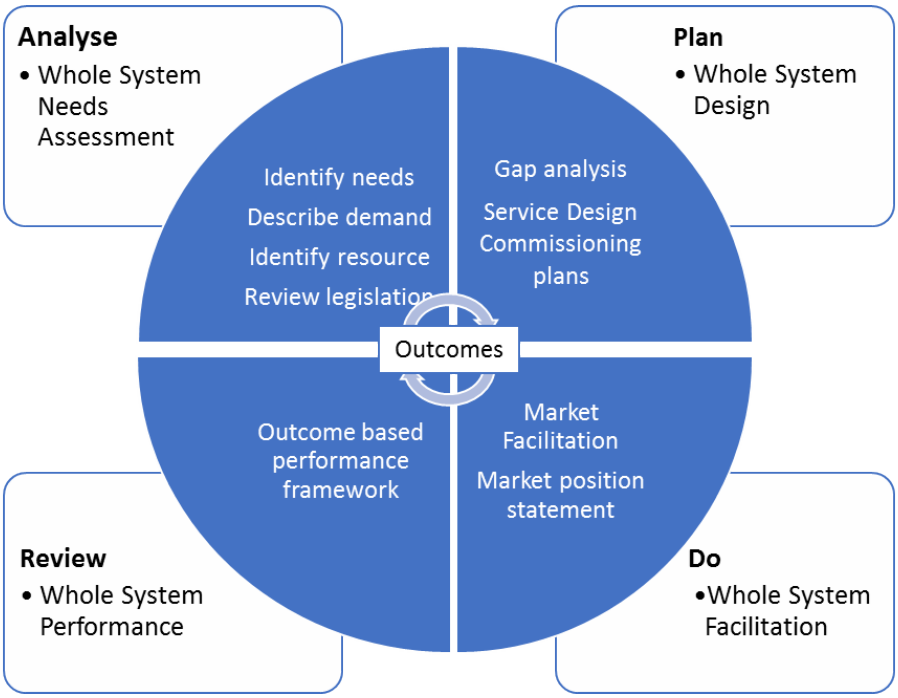
The Council and the Aberdeen City Health and Social Care Partnership (AHSCP) have jointly designed an approach to be adopted during any commissioning activity. This approach reflects recommendations made in the Scottish Government guidance document, 'Strategic Commissioning Plans Guidance 2015', namely:

- linked to strategy and outcomes
- collaborative approach
- based upon population needs assessment
- shifting demand focus to preventable demand through early intervention and prevention.

The figure below shows the strategic planning cycle within which our joint strategic commissioning approach is placed, ensuring that the link to strategy and outcomes is continuously maintained across our commissioning activity.



Within the strategic planning cycle, the following figure shows the four key elements of our strategic commissioning approach.



3.1 Whole-system needs assessment

This is an analysis stage in the strategic commissioning process. It is at this stage that we start to understand and express the needs of the population across the city, within localities and into smaller neighbourhoods.

Of critical importance to this process is the completion of a Population Needs Assessment (PNA). A PNA allows us to better predict the demands to be placed on the Council, the ACHSCP, and other partner organisations. A greater understanding of the demand, and the drivers of demand, supports informed decision-making about how best to meet the needs of the population, whilst at the same time making a determined and positive shift towards preventing demand through early intervention and prevention.

A PNA was developed in 2018, which underpinned the refresh of the Local Outcome Improvement Plan (LOIP), which in turn determined the content of both the Council Delivery Plan and the ACHSCP Strategic Plan.
The PNA is being continually updated as data becomes available and each iteration of the PNA is resulting in more in-depth analysis.

The PNA, by definition, includes a very broad range of data and analysis, drawn from multiple sources across multiple partners. During 2018 and 2019 significant steps have been taken to build increasingly close working arrangements between partners in relation to data, information and analysis.

The refreshed LOIP makes a commitment to shared intelligence across all partners.

In addition to understanding the needs of the population, we also have to give regard to the legal duties being placed on both the Council and ACHSCP. Work has been undertaken to develop a legislative tracker system which will enable us to understand the duties being placed on the whole system. Annually the Scottish Government publish a "Programme for Government", setting commitments to changes in both legislation and policy, many of which will have primary or secondary impact on the planning, funding and delivery of services. It is critical that the potential impact of any proposed changes is understood as early as possible, that opportunities to influence proposed changes are fully taken and that scenario planning is undertaken on the basis of likely changes.

The Government's intention is that service users and carers should increasingly assume the lead role in commissioning services to meet their own individual needs. Direct payments are the basis for enabling self-directed support. The Social Care (Self-directed support) (Scotland) Act 2013 recognised that choice and control for supported people cannot happen unless there is a sustainable market of providers and services to choose from. As the market moves from monopsony (where there is a single buyer) towards a marketplace, the role of the Council and ACHSCP will change from manager to facilitator, working in partnership to deliver personalised, quality support to the people that need it.

In order to do this the commissioning approach and system needs to be collaborative, with close working between statutory, third, independent sectors and the public. This approach is discussed further in 3.3 'Whole-system facilitation'.

3.2 Whole-systems design

This stage is concerned with identifying the gaps between what is needed and what is available and planning how these gaps will be addressed, reflecting best practice recommendations, and public consultation within available resources.

The opportunities through multi-agency working allow us to consider system-wide approaches and solutions to planning. Activities include:

- undertaking a gap analysis to review the whole system and identify what is needed in the future, based upon what we know about the needs of the population; and

- based upon this information, designing services to meet needs, with technological solutions being a central consideration.

To support the creation of a gap analysis, we need to understand the available capacity within the Council, ACHSCP, NHS Grampian and the Community Planning Partnership more broadly.

Work is under way across multiple agencies to develop an approach to demand management. This is providing a means to classify the nature of demand and gain greater understanding of responding to this demand. The intent is to understand the flow of demand through the perspective of the service user, customer or patient and therefore how services are being used and provided.

A joint strategic commissioning approach provides the opportunity to design services, to meet that demand differently and, in so doing, strengthen the resilience of the population and reduce the demand upon services. This constitutes a shift away from negative demand to value demand.

The following classification of demand is being adopted:

1. Value demand - these are the demands we want customers to place on the system and they should reflect the reason for our being. Reflecting the Scottish Government's own recommendations, this should prevent demand through earlier intervention and will be a positive step to take.

2. Negative demand - turning off negative demand has an immediate impact on our capacity. We can further subdivide negative demand into:

- Failure demand - demand from service failure or poor design
- Avoidable demand - demand arising from behaviours that can be influenced or changed
- Excess demand - providing a higher level of service than is needed
- Co-dependent demand - demand unintentionally reinforced and entrenched by service dependence
- Preventable demand - demand which could have been prevented by intervening earlier

This classification of demand is being used to produce a detailed analysis of demand across all commissioned services, including those commissioned within the Council and its group structure of ALEOs or externally within the supply chain.

To enable us to consider the design of services, an appropriate response is required to each category of demand. These will cover short, medium and long-term responses. In broad terms, removing failure demand and avoidable demand is likely to be deliverable as short-term wins; redesigning services around customers to remove excess demand / co-dependent demand will deliver medium-term benefits; whilst proactively removing the causes of preventable customer demand could require more fundamental and long-term change. This demand management methodology is currently supporting the redesign of

services and progress is being made towards identifying and managing multi-agency demand.

Capacity will move upstream to the design of services based upon assessment of need and the strategic approach to meeting that need. Our assumption is that if we increase capacity in the planning stage, our procurement intent will become clearer, and the development of contracts will be less time consuming. The overall ambition is to make known our commissioning intent. The purpose of this is predominantly to inform the market of planning and commissioning intentions for the future, to afford better opportunities for market stability, and to encourage wherever possible and appropriate, new investors to the city. We will do this in the form of a strategic commissioning pipeline, which describes our intended activity over the next three years. This pipeline will link to financial planning mechanisms.

It should be acknowledged that through whole-system design, we will make recommendations for both commissioning and decommissioning of services. The National Audit Office has developed key recommendations to be adopted as best practice during the decommissioning cycle. These recommendations include good communication, a focus on outcomes for people rather than on services and a clear rationale for decision-making. We will work with providers, service users and local communities throughout the decommissioning process to identify alternative solutions to make the necessary change when appropriate.

3.3 Whole-system facilitation

Ensuring that the services needed to meet the needs of the population are delivered as planned, and in ways which efficiently and effectively deliver the intentions and outcomes agreed, is the concern of this aspect of the cycle. Activities associated with this stage include the development and sustainability of the local provision, in particular ensuring that there is sufficient supply and capacity to ensure a mix of service providers to offer service users an element of choice in how their needs are met.

Whole-system facilitation calls for strengthening relationships with existing and potential providers. This can be defined as market facilitation. Market facilitation comprises three key components:

- Market Intelligence - the development of a shared perspective of supply and demand between commissioners and providers through shared intelligence and leading to a Market Position Statement. This statement, linking intelligence and strategy, sends a clear signal about the commissioning intent, allowing businesses and services to organise themselves and prepare for opportunities.

- Market Structuring - sets out how the market will operate and includes communication, monitoring and working together to improve outcomes.

- Market Intervention - based upon commissioning intent and market intelligence, interventions to support delivery of commissioned services.

A Market Position Statement should factor in all three of the aforementioned activities. This is a live document, which links to the strategic commissioning plans and the procurement strategy. It will be published, reviewed and updated regularly and steers the provider services towards meeting the needs of the local population through an outcome-based performance framework.

3.4 Whole-system performance

This element is concerned with monitoring the impact of services and analysing the extent to which they have achieved the intended outcomes.

The refreshed LOIP establishes a multi-agency outcome framework which ensures that a logical and systematic approach is taken to the delivery of outcomes through aligning planning, activity, performance monitoring and review, through the structures and governance of Community Planning Aberdeen.

In turn, partners reflect the shared ambition and priorities of the LOIP within their own organisational strategic plans i.e. the Council Delivery Plan and the ACHSCP refreshed Strategic Plan. These were both approved in March 2019 and include commitments, targets and measures from the LOIP.

Work is under way to further develop and integrate a partnership-wide Outcome-Based Performance Framework which reviews and analyses performance against shared outcomes.

It is important that outcome-based performance management is fully developed and becomes embedded in a regular cycle of commissioning. This means that in each strategic commissioning plan, and in each subsequent procurement, there is explicit measurement and review of performance both in terms of the delivery of services, but also of the impact which commissioning and procurement has on delivering outcomes.

SECTION 3: RELATIONSHIP BETWEEN STRATEGIC COMMISSIONING, PROCUREMENT AND CONTRACTING

Procurement planning acts as the bridge between strategic commissioning and procurement. As a result of the Procurement Reform (Scotland) Act 2014, contracting authorities are required to prepare a procurement strategy, setting out how the authority intends to carry out procurement. A group of two or more contracting authorities may have a joint procurement strategy. Contracting authorities are required to ensure that their procurement is carried out in accordance with the strategy and are required to prepare an annual procurement report. A brief outline is detailed in the Annual Procurement Strategy section below.

The IJB is not a contracting authority; directions are issued by the IJB which may require the Council or NHS Grampian to procure services. Therefore, the IJB's procurement processes are already aligned to those of the Council and NHS Grampian.

We have adopted the national procurement journey which supports all levels of procurement activity. There is specific process for procurement exercises below £50,000 and a separate process route for higher value, more complex needs. The processes facilitate best practice and consistency.

The national procurement journey provides one source of guidance and documentation for the Scottish public sector which is updated on a continual basis with any changes in legislation, policy and also facilitates best practice and consistency. The Council's procurement journey has been further developed as an online tool with a supporting guidance manual tailored specifically for both IJB and Council requirements. These tools are compliant with the Public Contracts (Scotland) Regulations 2015, Procurement (Scotland) Regulations 2016 and the statutory guidance. The national procurement journey was updated in March 2017 to include Care and Support Services procurements.

The diagram below shows the process flow of the three main zones: A - Development; B - Tender; and C - Contract.

The market analysis, spend analysis and specification build are the main activities undertaken in Zone A. A prime focus is on demand management through improvement of specifications targeted on outcomes and performance, spend consolidation, standardised needs and how to reduce consumption.

Zone B is more transactional and procedural in nature, involving the progression of the agreed procurement route to market and the publishing and advertising of documentation.

Zone C is focused on the procedures from actual contract award to subsequent mobilisation of suppliers and contract implementation and management.

At each of the processes within each of the zones, online guidance and template documentation is sequentially followed and populated by the Procuring Officer. Each Procuring Officer will now undertake a training programme which is proportionate to the level of spend and the complexity of the need they are involved with. On completion of the training, the Procuring Officer will receive Delegated Procurement Authority status.

The Council and IJB take advantage of national procurement frameworks to ensure best value. These frameworks not only give assurance on best value, the use of them mitigates the need for numerous and recurring individual procurement exercises.

A strategic commissioning approach is designed to ensure alignment with desired outcomes. The procurement cycle presents a further opportunity to contribute to outcomes through the use of Community Benefit clauses within contracting activity. The Procurement Reform (Scotland) Act 2014, allows a contractual requirement to be imposed relating to training and recruitment and availability of subcontracts, which is intended to improve the economic, social or environmental wellbeing of the area.

The Council's Community Benefits Policy was approved by the Strategic Commissioning Committee in November 2018. When the Council is procuring on behalf of the IJB, the Community Benefits Policy will be followed. The Community Benefits Policy consciously establishes links to national outcomes and local priorities. The Council's approach to community benefits is consistent with the 16 national outcomes in place since 2007 and is aligned with the National Performance Framework introduced in the summer of 2018.

The Community Benefits Policy is also conscious of emerging socio-economic considerations under the Fairer Scotland Duty and is designed to be sufficiently agile to adapt to emerging or shifting local priorities, ultimately linked towards measures designed to ensure the increased prosperity of citizens and communities.

A full listing of all community benefits delivered will be reported to the Strategic Commissioning Committee in November 2019.

SECTION 4: ROLES AND RESPONSIBILITIES WITHIN A STRATEGIC COMMISSIONING

This section describes the roles and responsibilities related to a joint commissioning approach both in terms of overall leadership and governance and for each of the elements of the commissioning approach previously described.

The roles and responsibilities are:

1. Joint Commissioning Leadership and Governance

Strong and clear leadership of the joint commissioning approach is required in order to:

- maintain an overview of the commissioning system, the outcomes it is trying to achieve and what risks need to be managed
- lead the development of joint commissioning plans and securing partners commitment to them
- ensure that all partners engage with the implementation of agreed plans
- ensure the delivery of strategic service change and improvement across the system
- review the strategic impact of services and getting partners to change direction when needed.

We need to place responsibility for this leadership within our existing partnership structures in order to ensure the joint approach. Therefore, we envisage the following playing a role:

- Aberdeen Community Planning Partnership board and the management group and its supporting outcome groups
- Aberdeen City Council's committees, as set out in the Scheme of Governance
- The proposed IJB strategic commissioning board.

2. Whole-System Needs Assessment

Increasingly joint needs assessment is being developed and undertaken by the intelligence and performance teams in ACHSCP; the Council and NHS Grampian. This is being systematically aligned with Community Planning through the PNA, ensuring that shared outcomes are defined, demand is understood and described across the whole system and resources are reviewed holistically.

A common, multi-agency approach to managing demand has been agreed and has begun to be implemented jointly. Review and communication of changing legislative duties is being conducted by the Council's Governance cluster.

Leadership and development of this element of the joint commissioning approach lies with Business Intelligence and Performance Management within the Council; Health Intelligence within NHS Grampian; and Strategy and Performance within the ACHSCP.

Outputs from this element (e.g. PNA; legislative reviews, etc) are reported to the Council's Strategic Commissioning Committee, the IJB and the Community Planning Partnership.

3. Whole-System Design

Building on joint assessment of needs, the activities of this stage are to undertake a gap analysis and to design services to meet needs. There is joint responsibility for these activities, between shared intelligence professionals across the partners and the lead commissioners at a service level.

The groups and structures which will be used to support this stage of the cycle include:

- the Aberdeen city multi-agency transformation groups
- the North East IJB Transformation CEO Group and the North East IJB Chairs Group
- within the Council as a single system, it is the role of the Extended Corporate Management Team to oversee service redesign proposals.

4. Whole-System Facilitation

Market facilitation comprises three key components: market intelligence; market structuring and market intervention. The Chief Officer, Commercial and Procurement, is responsible for coordinating market facilitation across all service areas within the Council and in partnership with the Lead Commissioner, IJB, for adult social care.

The IJB is required to produce and publish an annual Market Position Statement and the Lead Commissioner within the IJB is responsible for this. The Council is not required to publish a market position statement; however an Annual Procurement Strategy is required and the content of this strategy includes the commissioning intentions for each financial year. The Chief Officer, Commercial and Procurement, is responsible for producing the Annual Procurement Strategy.

5. Whole-System Performance

The establishment of an Outcome-Based Performance Framework which reviews and analyses performance in the delivery, through planned commissioning and procurements, of shared outcomes is the responsibility of Business Intelligence and Performance Management within the Council; Health Intelligence within NHS Grampian; and Strategy and Performance within ACHSCP.

Outputs from the Outcome-Based Performance Framework will be reported to the Council's Strategic Commissioning Committee, the IJB and the Community Planning Partnership.

SECTION 5: WORKFORCE CAPABILITY AND DEVELOPMENT TO SUPPORT STRATEGIC COMMISSIONING

The Scottish Government produced a learning development framework [i] to assist all those involved in the strategic commissioning process and highlighted the following areas to develop expertise in:

- Joint commissioning for better outcomes

There is agreement about the importance of outcomes as drivers for good health and care services. In joint commissioning this means something very practical but often difficult to achieve - that services are designed, developed and delivered in a way which secures the best possible overall impact or result. This challenges services which are designed for professional or administrative convenience, which focus only on one aspect of a person's overall care needs, or without evidence that they are successfully improving outcomes for those who use them.

Outcome-based commissioning means starting from the needs of the population and configuring resources across social care, community and acute health, housing, welfare benefits, and community development (whoever owns them), to best meet those needs.

- Commissioning based on co-production

Commissioning is not about simplistic marketisation or privatisation of health and social care. It is not only about procurement of services from external suppliers. It is about a mature relationship between different partners from across the public, private and voluntary sectors in a way which will help to achieve the best services for the population.

Every partner has a role to play in joint commissioning and that is why it is important that local arrangements promote mature relationships and constructive dialogue. Those involved in the joint commissioning task need to develop their skills in working with a range of partners including the public, private, and third sectors and with service users, patients and carers, to build and implement commissioning priorities.

- Maximising service user and patient engagement in commissioning

Co-production involves the effective engagement of service users, patients, carers and the wider public in decisions about the future of services. Developing effective dialogue between commissioning organisations and the public can be strengthened through effective engagement in understanding need, reviewing resources and planning evidence-based services.

- Commissioning for self-directed support

There is a commitment to promote greater choice and control for individual service users and patients through self-directed support and person-centred care. Joint commissioning has a key role in ensuring that services delivered or funded by the Council and the NHS are designed to make sure that their users are fully able to direct their care service and get the support they need when they need it.

- Market facilitation

Health, social care and wellbeing support for older people is not funded by any means entirely through publicly funded sources or always managed directly by public agencies. Many people buy some of their own health and social care, or make use of family, informal voluntary and community services, or use self-directed support.

It is increasingly important that the Council and NHS colleagues understand the contribution that these services make, ensure that they are taken into account when planning new developments, and that they are helped to make the best possible contribution to achieving good outcomes for older people, even if they are not funded directly.

In building our joint commissioning and procurement skills and capacity, we start from a position of already having many people already involved to some degree in the commissioning and procurement tasks. Sufficient capability exists within the specialist procurement function, which will be further enhanced by the development plans produced as a result of the council's new capability framework. The priority must be the development of the commissioning skills as set out in the Scottish Government development framework.

[i] Joint Strategic commissioning – a learning development framework IPC November 2012

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Appendix 2: Progress so far against the elements of a strategic commissioning approach

PLAN

The ACHSCP refreshed Strategic Plan was approved in March 2019. Work has also commenced to develop Grampian-wide strategies for the acute-based services which IJBs have strategic planning delegated for. Mental Health & Learning Disability, Older People and Palliative care have all progressed and are at consultation stage.

REVIEW

A Strategic Implementation Dashboard (SID) was also developed which captured these commitments, targets and measures and these have been allocated to each of the five Strategic Aims within the Strategic Plan giving a delivery dashboard for each. Performance against the aims is reported to both the Audit and Performance Systems and Clinical and Care Governance Committees throughout the year, with the IJB receiving reports on the National and MSG Indicators.

ANALYSE

Work is under way to more closely align our performance and risk frameworks and to ensure that all future commissioning is based on a sound understanding of the data that evidences the commissioning need.

PROCUREMENT

The IJB does not procure directly but provide directions to NHS or ACC, at which time they follow their procurement process. The discipline of issuing a direction which provides the instruction to either NHS or ACC to procure is well established.

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ROLES AND RESPONSIBILITIES

The Leadership Team objectives have been based on the targets and measures within SID and performance is monitored on a quarterly basis by the Chief Officer and Chief Finance Officer. The Lead Commissioner has 12 commissioning-specific objectives. Although each objective has a Lead Officer, work has been undertaken to identify the linkages between the objectives to map out what activity is contributing to the delivery of each. This could include activity that is also contributing to the delivery of one of our partner plans.

Next Steps in the sequencing of the adoption of a strategic commissioning approach by the IJB

ANALYSE

We will complete the data compilation required to undertake the Market Position Statement.

PLAN

ACHSCP will progress with the development of a Strategic Commissioning Board. Work will be undertaken to further define the terms of reference for this board, but the underlying principles and broad function of this board will be to ensure that there are necessary leadership and governance arrangements in place – both to ensure consistency and transparency of decision-making, and to ensure that the principled commissioning approach described within the Strategic Plan are being adhered to.

The Board will also oversee progress with the implementation of the Strategic Commissioning Plan. The membership of the Board will have sufficient knowledge, experience and authority to advise and mitigate against any risks to progress. The membership of the Board also needs to reflect the principles of joint strategic commissioning and will include partners from the statutory, third and independent sectors and public representation. The Board will oversee the adherence to a shift towards system-wide strategic commissioning

It is essential that this Board membership reflects the system in which we operate, Acute-based services for which the IJB has delegated strategic planning; third and independent sector engagement is fundamental to progressing this.

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The three-year commissioning plan which is being submitted to IJB in November will provide the direction of travel of review and redesign of delivery.

In addition, the current Grampian-wide strategic plans out for consultation, (MH&LD, Older people & palliative care) will be the areas on which we will focus on this commissioning approach.

The following framework will facilitate this process:

Principle	**Requirement**	**Evidence**
Undertaken for outcomes	That the commissioning activity is based upon the achievement of outcomes for people rather than for services	Links between the needs assessment (now and future), public opinion and consultation, and the expected outcome that the commissioning activity will achieve
Based upon evidence and insight	That the commissioning activity reflects best practice, public opinion, local knowledge, and that there is a golden thread to strategy	Best practice examples, public consultation, local knowledge of market
Consideration of sustainability	Plans are in place from the start of the commissioning process which ensures as far as is reasonably possible that the commissioning activity takes into consideration the financial and workforce sustainability, for the duration of the commissioning arrangements	Market knowledge, financial forecast
A system-wide approach	Commissioners have identified different parts of	Identification of the different parts of the system involved

INTEGRATION JOINT BOARD

	the system that have a part to play / will be impacted upon by the proposed commissioning activity	and evidence of a joint commissioning approach
Enabling prevention through early intervention	Commissioned services make a definite shift towards early intervention and prevention	Evidence of the intended consequence of the commissioning activity
Balances innovation and risk	An innovative approach is adopted at every opportunity; it is important that any risks in doing so have been identified and control measures are in place	Commissioning plans will include new ways of working, including technological solutions; any risk implications are identified and a risk plan with control measures is available
Based upon sound methodology and appraisal of options	Transparent decision-making processes are in place	The use of an options appraisal to arrive at decisions
Co-designed and co-produced with partners and members of the public	Co-design, co-production and consultation is at the heart of any commissioning activity	Evidence of co-design, co-production and consultation
Performance monitoring	An identified means and mechanism of how this commissioning activity will be monitored	Links to performance dashboard, outline service specification

DO

A Market Position Statement (MPS) will be produced as a succinct and confident analysis of the local market across the whole system within the ACHSCP. It will provide an analysis of current and anticipated projections of need. It will include and highlight particular areas of demand now and in the future and will clarify our commissioning intentions.

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The MPS requires good information, succinct analysis and a willingness to engage with many different stakeholders in a way which promotes a genuine and meaningful dialogue. It has an essential role in securing the types of services needed in the future to deliver services to meet the needs of the local population.

We plan to work through the Oxford Brookes toolkit with a range of stakeholders to develop our MPS and will seek support from both ACC and NHSG in collecting, collating and analysis of the required data.

REVIEW

The impact of this approach will be reviewed through monitoring of the progress of outcomes within the IJB Strategic Plan.

PROCUREMENT

The IJB procures through providing direction to NHSG and ACC; this process is planned for internal audit and any recommendations will be implemented accordingly.

A self-assessment was completed based on the recommendation of the MSG report on the progress of integration; this self-evaluation and an action plan to progress was approved by the IJB in March 2019. We will continue to progress with the specific actions which are impacted through a joint commissioning process.

ROLES AND RESPONSBILITIES

The Lead Commissioner will have responsibility for delivering on the following which will deliver on the action plan following the MSG self-evaluation:

- Providers and Partners Network (PPN) to develop agreed actions on how best to promote and sustain good relationships across all sectors, organisations and staff roles
- PPN to evaluate cross-sector relationships and impacts
- the Commissioning Lead will submit a report to the IJB on a jointly developed commissioning approach which includes an outcome performance framework

- the Commissioning Lead will submit a report to the IJB in August on a jointly developed approach to market facilitation
- the Commissioning Lead will submit a three-year commissioning plan to the IJB in November of this year.

The Strategic Commissioning Board will have a key role and responsibility to facilitate the change in approach. The adoption of a commissioning approach by the IJB to planning the design and delivery of acute services represents a significant change and it will be essential that the IJB adopts this approach in partnership with the Acute sector. Therefore, much consideration will be given to the membership of the proposed Strategic Commissioning Board to ensure the appropriate involvement of the Acute sector and advice will be sought from all the relevant Acute clinical and professional leads and structures to ensure the full engagement of Acute services in the development of the approach.

WORKFORCE DEVELOPMENT

The development of skills required for this joint approach is required.

We will work with both ACC and NHSG to align key staff within established and planned training programmes relevant to commissioning and procurement.

In addition we will seek to source the opportunity to not only develop our staff but the members of the Strategic Commissioning Board; a skills analysis will be undertaken and a development plan for this Board will be put in place to ensure we have the appropriate level of skills, knowledge and aspirations which are required.

INTEGRATION JOINT BOARD

STRATEGIC COMMISSIONING – KEY MILESTONES

Milestone	Approximate Date
Strategic commissioning approach approved	September 2019
Strategic commissioning board established	September 2019
Three-year strategic commissioning plan developed and approved	November 2019
Skills analysis and development plan for the strategic commissioning board members	January 2020
Milestone progress report delivered to the IJB	February 2020
Market position statement developed, and approved	October 2020

INTEGRATION JOINT BOARD

Draft Terms of Reference

Strategic Commissioning Board

1. GENERAL

These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Aberdeen City Health and Social Care Partnership (ACHSCP) Strategic Commissioning Board.

2. PURPOSE

The purpose of the Board is to:

- oversee the implementation of the Strategic Commissioning Plan
- ensure that there are the necessary governance arrangements in place for the implementation of the plan; this will include robust and transparent decision-making processes on commissioning and de-commissioning decisions
- ensure that any commissioning and de-commissioning decisions follow the framework advocated within the strategic commissioning approach.

3. RESPONSIBILITIES OF GROUP MEMBERS

- provide leadership
- make objective decisions
- consider the whole system in the context of strategic commissioning
- ensure governance processes are observed
- ensure best value is achieved with regard to strategic commissioning decisions.

4. OUTPUTS

- a ction note
- r ecommendations for onward progression to the Executive Programme Board

INTEGRATION JOINT BOARD

• S trategic Commissioning Report – annual

• s trategic commissioning three-year plan

5. MEMBERSHIP

- Lead Commissioner ACHSCP
- Chief Finance Officer ACHSCP
- Lead Social Worker ACHSCP
- Lead for Mental Health and Learning disability ACHSCP
- NHS Grampian Health Intelligence
- Head of Commercial and Procurement Services ACC or depute
- Scottish Care representative
- ACVO representative
- NHS Grampian acute services (ARI)
- NHS Grampian MHLD services
- Public representative
- NHS Grampian Procurement representative

6. ATTENDANCE

Full attendance would be required for core group members either by the nominated person or a delegate. Other attendees will attend by invitation only.

7. FREQUENCY OF MEETINGS

The group will meet bi-monthly.

8. REPORTING

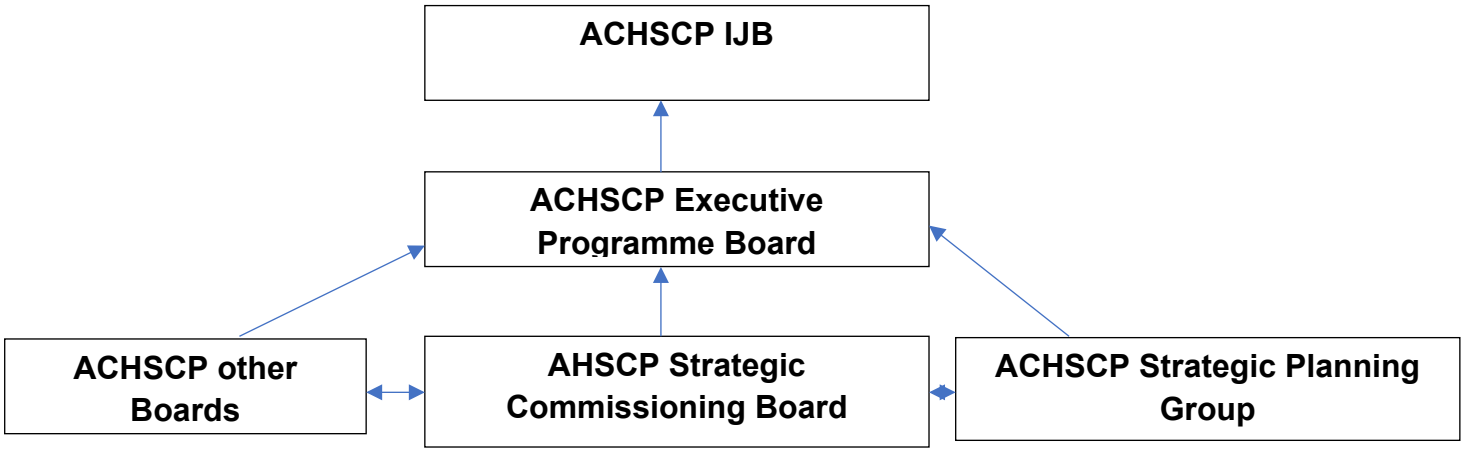
The group will report in to the ACHSCP Executive Programme Board

9. CONFIDENTIALITY

INTEGRATION JOINT BOARD

All discussion at the working group meeting will be treated in strictest confidence. The group will agree key messages which will be shared as appropriate.

10. REPORTING ARRANGEMENTS



INTEGRATION JOINT BOARD

Appendix 3: What are the main differences between our current and future approach to commissioning?

Current Position	Future Position
Reactive - driven by the duration of the contract	Proactive - driven by the needs of the population, now and in the future
Monopsony with statutory sector being the key player and decision maker	Shared approach, acknowledgement of shared risk, co-design, co-production, collaboration
Sustainability for the duration of the contract	Sustainability for the longer term
Redesign opportunity not maximised	Strategic commissioning having a key role in transformation
Focused on the service to be delivered	Focused on the outcomes to be achieved
Time spent on procurement process	Time spent to determine the right thing to do to maximise outcomes therefore procurement and contract design takes less time.
Single-system approach	Whole-system approach
Lack of clarity to the market about commissioning intent; mismatch of provision and demand	Clear direction to the market about commissioning intent; opportunity for the market to align itself to strategic needs
Performance indicators isolated to the individual contract	Outcomes based upon the ambitions of the Strategic Plan
Often a refresh of current provision	Review, with the opportunity to be creative, innovative and utilise technological solutions

INTEGRATION JOINT BOARD

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	Transformation – Decisions Required: Digital, Immunisations and Delayed Discharge
Report Number	HSCP.19.052
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Gail Woodcock Lead Transformation Manager gwoodcock@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	a. Interim Very Sheltered Housing Business Case b. Interim Very Sheltered Housing Direction to ACC c. Health Visiting Digitisation Business Case

1. Purpose of the Report

1.1. This is one of three transformation reports seeking approval to agree financial expenditure to progress a number of projects which support the delivery of our Strategic Plan.

1.2. The purpose of this report is to request approval from the IJB to incur expenditure, and for the Board to make Directions to NHS Grampian and Aberdeen City Council, in relation to projects that sit within the Partnership's Transformation Programme in respect of the Digital and Delayed Discharge programmes.

1.3. The projects relate to strategic intentions, as set out in the overall Transformation Plan, the Primary Care Improvement Plan (PCIP) and the Action 15 Plan which have been previously approved by the IJB, as key areas of change for delivering on the Strategic Plan.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

a) Approve the expenditure, as set out in Appendix A, relating to the Interim Very Sheltered Housing project.

b) Instruct the Chief Officer to make the Direction to relating to the Interim Very Sheltered Housing project as per Appendix B to Aberdeen City Council.

c) Approve the preferred option as set out in the Business Case in Appendix C in relation to Health Visitor Digitisation and note that discussions will continue with NHS Grampian to identify the funding for this option, with the aim of it becoming operational by November 2019. Note that the Health Visiting Digitisation Business Case will also be reported to the Asset Management Group of NHS Grampian.

3. Summary of Key Information

Background

3.1. Good governance and delegation levels require the IJB to approve the level of expenditure on these projects and make Directions to both NHS Grampian and Aberdeen City Council that will enable funding to be released to deliver the projects. The governance structure in place has and will continue to ensure effective operational and executive oversight.

3.2. This report seeks authorisation from the IJB to incur expenditure in respect of items which have been considered and recommended for approval in principle by the Executive Programme Board and discussed and developed through Working Groups where appropriate.

3.3. In order to allow this report to be considered in a transparent manner, details relating to finances have been attached as confidential appendices.

INTEGRATION JOINT BOARD

Transformation Programme

3.4. The transformation programme has recently been prioritised in line with the refreshed Strategic Plan. A list of the programmes along with their links to the Strategic Plan, Medium-Term Financial Framework and Strategic Risk Register is set out below:

Transformation Programme of Work	Links to Strategic Aims & Enablers	Links to Strategic Risk Register*	Links to Medium Term Financial Framework	Comments
Primary Care Improvement Plan	Resilience Personalisation Communities	1, 2, 5, 7, 9	Transformation	Agreed by IJB in July 2018 Specific Funding Source.
Action 15 Plan	Prevention Resilience Personalisation Communities	2, 3, 5, 7, 9	Medicines Management Transformation	Agreed by IJB in July 2018 Specific funding source
Alcohol and Drugs Partnership Plan	Prevention Resilience Personalisation Communities	2, 4, 5, 7, 9	Transformation Medicines Management	Agreed by IJB in December 2018 Part of Community Planning Aberdeen's Local Outcome Improvement Plan Specific funding source
Locality Development Transformation Programme	Prevention Resilience Personalisation Communities Connections	1, 2, 4, 7, 8, 9	Transformation Medicines Management Efficiency Savings Service Redesign	Will capture change actions identified in locality plans. Will also include significant cross-cutting projects such as Unscheduled Care and Social Transport
Digital Transformation Programme	Prevention Resilience Personalisation Communities Connections Digital Transformation Modern & Adaptable Infrastructure	1, 2, 7, 9	Efficiency Savings Transformation Medicines Management Service Redesign	Will support the delivery of the Digital Strategy
Organisational Development Transformation Programme	Prevention Resilience Personalisation Empowered Staff	6, 7, 8, 9	Service Redesign Transformation	Will support the delivery of the Workforce Plan
Efficient Resources Transformation Programme	Prevention Resilience Sustainable Finance	1, 2, 7, 9	Efficiency Savings Transformation Service Redesign	Utilising Lean Six Sigma methodology, working deep within teams delivering services to reduce variation and increase efficiency

Resilient, Included and Supported Outcome Improvement Plan	Prevention Resilience Communities Connections	4, 7, 8	Medicine Management Transformation	Part of Community Planning Aberdeen's Local Outcome Improvement Plan. No specific funding source

Interim Very Sheltered Housing

3.5. The Very Sheltered Housing Interim project (which is described in detail in the business case at Appendix A to this report) offers an additional opportunity to provide dedicated capacity to support patients/clients safely out of hospital.

3.6. In summary, the project entails the repurposing of under-utilised housing with care (also known as Very Sheltered Housing) flats within Aberdeen City to support those waiting in hospital for that level of care and support. NHSG Acute; Occupational Therapy; Woodend Hospital and Royal Cornhill Hospital, amongst others, have endorsed the project as appropriate and would support it. The business case has been reviewed and approved by the Executive Programme Board.

3.7. The use of such an interim type service would align with the suite of services that the partnership has put in place to date relating to flow out of hospital. It is also congruent with the Grampian-wide "moving on" policy, which puts an emphasis on appropriate interim discharge arrangements being utilised once an individual is clinically fit for discharge.

3.8. There are known benefits to patients/clients from being discharged from hospital as soon as they are well enough to do so. These benefits include a significantly reduced risk of infection, reduced risk of deconditioning, and improved confidence regarding independent living.

3.9. Any patient/client who utilised an Interim Very Sheltered Housing placement would continue to be prioritised in the same way as a hospital-based delayed discharge for any services/supports, i.e. an individual would not be disadvantaged and wait longer for a permanent placement due to moving to the interim service.

Digitisation of Health Visiting

3.10. Health Visiting has been experiencing recruitment difficulties for some time. There has been limited success in mitigating this, other than seeking to recruit additional health visitors. Some success was achieved through employing additional staff in administrative and immunisation support roles to reduce health visitors' workloads.

3.11. The Lead Nurse has recently highlighted the impact of staff shortages on the provision of universal services to under-5s across the city.

3.12. In January 2019 it was established that a wider range and understanding of potential mitigation factors was required. One significant mitigation identified was the introduction of a scheduling and caseload management system and the opportunity of mobile working.

3.13. Health visiting in the city currently utilises traditional paper-based systems to support, plan and capture their work. This system is inefficient, requiring duplication of processes and additional travel time to base prior to undertaking appointments. In addition, the system is burdened by bureaucratic processes.

3.14. It is understood that there is a desire by partners to have one system for the whole of Grampian with the ability to engage across multiple software systems to improve multi-agency working. Given Aberdeen City had a higher risk of failing to meet the universal pathway for under 5s, it was felt that an interim solution should be considered.

3.16. During the period of the options appraisal and business case being prepared Health Visiting salaries have been increased due to a national re-grading of this role. This has resulted in an increased interest in posts and as such we will now be able to potentially fill vacancies, increase staffing and mitigate the risks to service users. However, this does not address the inefficiencies in the systems and procedures currently used by the Health Visitors.

3.17. There is a need to balance bringing increased efficiency and productivity with ensuring that we recruit to appropriate workforce requirements and focus on delivery of the pathway to every child in the city. To this end and in partnership with the Director of Nursing we will run the workforce tool quarterly and monitor set of agreed performance indicators, to measure the impact of change, transformation and success, the expectation and premise of this approach being that as we increase efficiency, productivity and process we enable Health Visitors to spend more time on direct contact improving the outcomes for children across the city.

3.18. We are proposing to bring in phased increases in staffing across the initial three years as determined by the workforce tools. Doing this incrementally will take cognisance of the digital solution and support the mobile solution; it is anticipated that many risks especially in cases of vulnerability will be minimised quickly.

3.19. Work has been undertaken to scope out the implications for moving to a digital solution for health visiting in the city. This would involve Health Visitors having a mobile device and an electronic system to manage their appointments and update clinical case notes. The impact of this work on quality and safety will be monitored through the Grampian Clinical Governance Committee.

3.20. Technical analysis, including site visits and technical demonstrations, were carried out on nine potential operating systems to assess the suitability for the health visiting service's needs, along with detailed scoring and recommendations. These are included within the business case at Appendix C.

3.21. This proposal in Appendix C has been developed in partnership with senior officers from NHSG to fully explore the context and minimise the impact of any potential unintended consequences. The process used during the development of this business case has involved Health Visiting staff and

they are supportive. Engagement with staff side and union colleagues has also been undertaken.

3.22. Savings will be identified following the implementation of the system to cover the ongoing costs. Discussions are currently taking place with senior officers within NHSG to determine what level of financial support they can provide towards this project going live in November 2019, particularly given there may be merit in rolling this system out in other services.

3.23. The business case details potential benefits for service users and staff and has been approved by the Executive Programme Board. As health visiting is a service that remains accountable to NHS Grampian (it is not within the IJBs Scheme of Delegation), the proposal is also being reported through NHSG Asset Management Group. The IJB is asked to agree to incur the expenditure as it is accountable for the operational budgets pertaining to this service.

4. Implications for IJB

4.1. Equalities

It is anticipated that the implementation of these plans will have a neutral to positive impact on the protected characteristics as protected by the Equality Act 2010.

4.2. Fairer Scotland Duty

It is anticipated that the implementation of these plans, will have a neutral to positive impact on people affected by socio-economic disadvantage.

4.3. Financial

The recommendations in this report will result in financial expenditure from the Integration and Change budgets. Full details of the financial implications are in the associated business cases.

4.4 Workforce

Implementation of the Health Visiting Digitisation project will involve new ways of working for health visitors, and appropriate training will be provided.

Due to the anticipated scale of change in terms of service delivery, consultation and engagement with staff and trade unions will be key throughout all aspects of transformation. The success of our ambitions will depend on our staff, and hence Organisational Development and staff training will be a key aspect of delivering transformation.

4.5 Legal

At this time, there are no anticipated legal implications for the projects referred to in this report.

4.6 Other - N/A

5. Links to ACHSCP Strategic Plan

5.1. The recommendations in this report seek to deliver aspects of the wider Strategic Plan including supporting and improving the health, prevention, wellbeing and quality of life of our local population, and supporting our staff to deliver high-quality services that have a positive impact on personal experiences on outcomes.

6. Management of Risk

6.1. Identified risks(s)

Risks relating to the Transformation Programme are managed throughout the transformation development and implementation processes. The Executive Programme Board and portfolio Programme Boards have a key role to ensure that these risks are identified and appropriately managed.

6.2. **Link to risks on strategic or operational risk register:** The main risk relates to not achieving the transformation that we aspire to and the resultant risk around the delivery of our strategic plan, and therefore our ability to sustain the delivery of our statutory services within the funding available.

INTEGRATION JOINT BOARD

9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

2. There is a risk of financial failure, that demand outstrips budget and the IJB cannot deliver on priorities, statutory work, and project an overspend

6.3. How might the content of this report impact or mitigate these risks:
The report seeks approval to progress a number of projects which will directly positively contribute to mitigating these risks.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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	Business Case - Summary	Project Stage **Define**

Project Name	Interim Very Sheltered Housing Provision	**Date**	21-08-2019
Author	Kenneth O'Brien (Service Manager, Aberdeen City H&SCP)	**Version**	1.2

Contents

1. Business Need

The Aberdeen City Health and Social Care Partnership has already invested in multiple interim services to support discharge/flow out of hospital. This has included interim care home beds and interim flats for those needing adaptations and level access rehousing.

One discharge destination which the partnership has, as yet, not built an interim pathway for is that of Very Sheltered Housing (VSH). Delayed discharge patients/clients who normally require VSH provision directly from hospital tend to be individuals who have both notable social care needs and a requirement for level access accommodation that can be easily adapted. Because of the relatively small property base that is commissioned/utilised as VSH (and the fact it is treated as a tenancy/property for allocation purposes), there can be a significant delay between an individual being identified as being appropriate for VSH and the allocation of a property.

In 2018 13 patients/clients were delayed awaiting Very Sheltered Housing with 261 hospital bed days lost to such delays. If we utilise the NHS Grampian lowest bed day cost figure of £279 per day per bed, the delayed discharge bed day cost of these delays equated to £72,819 in 2018.

There is therefore a very real business need to identify a legitimate option for addressing VSH delayed discharges. This is an issue given the national and local priority that has been put on addressing delayed discharges within a reducing hospital bed base. It is also hoped that having a 'temporary' option for VSH level needs will encourage "positive risk taking" practice with more patients/client being supported to try a VSH level service as opposed to permanent residential/nursing care.

The use of an interim option also aligns with the Grampian-wide 'moving on' policy which highlights the requirement for patients/clients to move from hospital beds once clinically fit for discharge

2. Objectives

The objectives for the project are:

- *reduction in the number of delayed discharge bed days lost to VSH delays*
- *increased flow out of the older adult's rehabilitation pathway*
- *better outcomes for patients/clients (less risk of deconditioning/infection) as they will be in an appropriate non-hospital setting sooner.*

2.1 Scoring of Options Against Objectives

Objectives	Options Scoring Against Objectives							
	Do Nothing	Use Care Home Beds	Use Underutilised housing with care flats	4	5	6	7	8
Reduction in number of delayed discharge bed days lost to VSH delays.	0	2	3					
Increased flow out of the older adults' rehabilitation pathway.	0	1	3					
Better outcomes for patients/clients (less risk of deconditioning/infection) as they will be in an appropriate non-hospital setting sooner.	0	1	3					
Total	0	4	9					
Ranking	3	2	**1**					

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

2.2 Recommendation

Based on the options appraisal above, it is recommended that **option 3** be pursued.

Presently, the partnership commissions from Voluntary Services Aberdeen (VSA) 40 flats at Cloverfield Grove and 41 flats at Broomhill Park which are block-funded to deliver social care for their residents at the 'upper end' of VSH dependency levels. These flats have been found to be challenging to let to full occupancy – resulting in at least five flats (sometimes more) being vacant consistently over the last 18 months. Vacancy levels have remained consistent despite evaluating unmet need and introducing lower age criteria and "marketing" the resource to mental health colleagues as well as Care Management.

Option 3 would take what has already been learned from the interim housing project and apply it to our Very Sheltered Housing delayed discharges. This would involve, for a trial 12-month period, the partnership taking over the full costs of five of the flats at Cloverfield Grove / Broomhill park. The partnership would use these flats to place individuals on an interim basis who require Very Sheltered Housing and are fit to leave hospital but do not yet have an identified VSH tenancy. If for any reason there was a lack of VSH level patients/clients to be placed, care at home delayed discharges could also be placed in the flats on a temporary basis.

Advantages:

- Makes use of an existing service which is already paid for regarding care provision, but currently under-utilised – cost effective
- Provides interim care in a setting that is appropriate and at the right level of dependency/support for those awaiting VSH.

Disadvantages:

- Will require some initial one-off outlay to ensure that the flats are furnished, equipped and set up for interim patients/clients.

This option offers the best way to address VSH delayed discharges without reducing care home capacity within the city or risking inappropriate placement of patients/client who may then become deconditioned.

3. Benefits

3.1 User Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Reduction in delays accessing VSH 'type' service from hospital.	VSH delayed discharge bed days	DD census submission	261 bed days per year	At least 60% reduction	By end of pilot	Monthly (at census)

3.2 Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency

3.3 Resources Benefits (financial)

Benefit	Measures	Source	Capital or Revenue?	Baseline (£'000)	Saving (£'000)	Expected Date	Measure Frequency
Reduction in bed days lost to VSH delays (currently non realisable financial savings)	VSH delayed discharge bed days	DD census submission	Neither – indicative only	None – no savings so far relating to VSH delays	£43691	End of pilot	Monthly (at census)

4. Costs

4.1 Project Capital Expenditure & Income

(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
One-off furnishing/outfitting of the 5 flats.	£10,250										
One off Occupational Therapy Adaptations + Purchase of specialist adjustable community beds for all 5 flats.	£12,000										
Sub-Total	**£22,250**										

4.2 Project Revenue Expenditure & Income

(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Rental (5 flats)	£43,325										
Council Tax (5 flats)	£6,875										
Utilities (5 flats)	£8,000										
Sub-Total	**£58,200**										

NOTE: All 3 of these costs are re-evaluated 1st April – so costs may vary slightly post 1st April 2020 during the 12-month project. It has been confirmed that these are the same costs levied to all tenants within the VSA Housing with Care services.

5. Time

5.1 Time Constraints & Aspirations

The overall VSA Housing with Care contract is set to conclude/be reviewed on 31st March 2020. As noted above, Commercial and Procurement staff will extend the contract by a sufficient time period to allow this project to go ahead as outlined.

5.2 Key Milestones	
Description	**Target Date**
Business case put through governance and project approved	September 2019
Protocol governing admissions agreed between Partnership and VSA	September 2019
5 flats identified and outfitting of them for admissions is completed.	September 2019
First admission to the flats	October 2019

*Note – this is a summary version of the Business Case, the full Business Case is available on request to IJB board members.

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **ABERDEEN CITY COUNCIL** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.19.052

Approval from IJB received on: 3rd September 2019

Description of services/functions: Funding of FIVE Very Sheltered Housing (VSH) Interim properties including costs of adaptations, furnishings and running costs as set out in the business case at Appendix 1.

Reference to the integration scheme:

Services – Services Listed in Annex2, Part 2 of the Aberdeen City Health & Social Care Partnership Integration Scheme

Functions – Functions listed in Annex 2, Part 1, of the Aberdeen City Health and Social Care Partnership Integration Scheme

Link to strategic priorities (with reference to strategic plan and commissioning plan):

- The partnership's Strategic Plan set a very clear intention to shift the balance of care to community-based models. The VSH interim project's focus on supporting flow out into the community from hospital is congruent with this goal.

Timescales involved:

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

Start date: As soon as all adaptations and furnishings are complete post funding approval.

End date: 12 months post commencement of admissions.

Associated Budget: Total costs over a twelve-month period of £80,450.

Details of funding source: Integration and Change Funding

Availability: YES.

[NOTE: some costs are re-evaluated 1st April 2020 – so costs may vary slightly post 1st April 2020 during the 12-month project.]

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

	Business Case	Project Stage **Define**

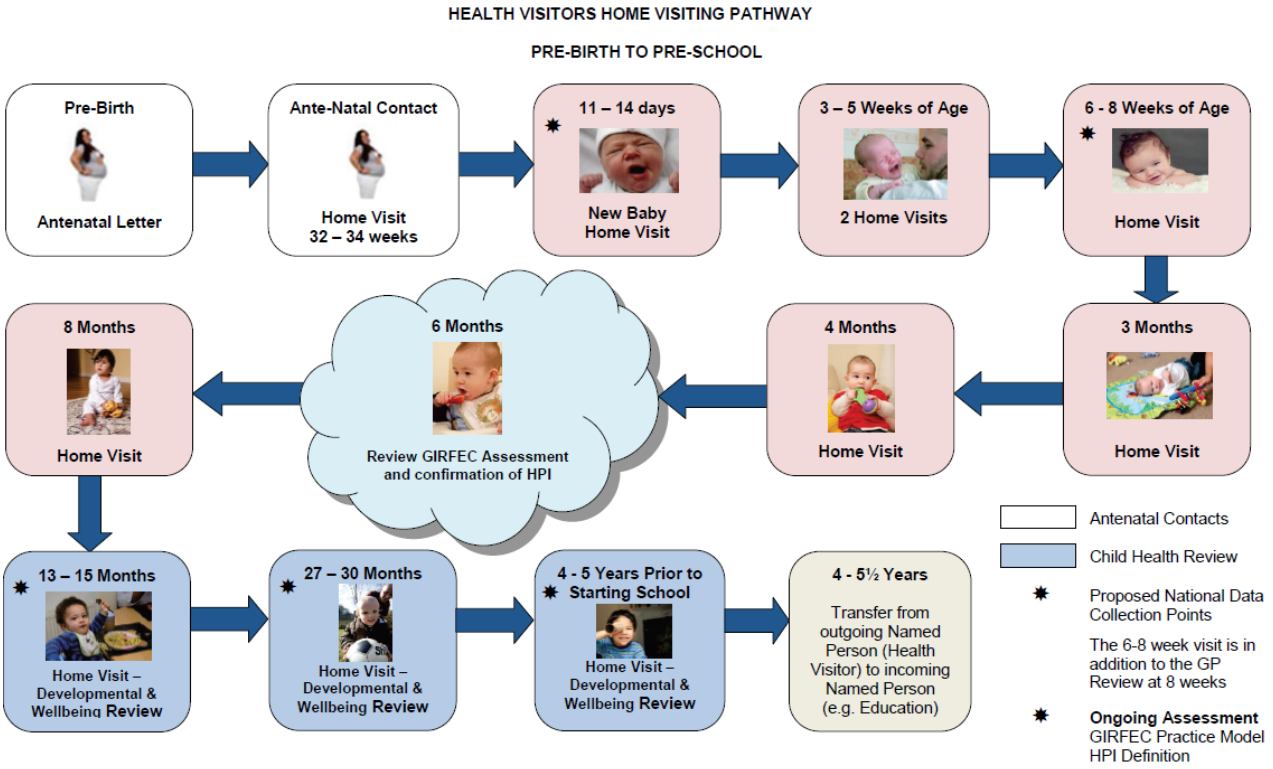
Project Name	Health Visitor Digitalisation	**Date**	July 2019
Author	Michelle Grant/Eve Whyte	**Version**	2.0

Contents

1. Business Need

The Health Visiting Service assess the developmental health and wellbeing of all children between the ages of ten days to five years (or when the child starts school). Within this time, the Health Visitor acts as the named person for the child and will intervene where additional support is required. The Health Visitor is central to any further interventions. The named person service is a central part of the Scottish Government's 'Getting it right for every child' (also known as GIRFEC) policy, the national approach in Scotland to improving outcomes and supporting the wellbeing of our children

The national Universal Health Visiting Pathway dictates a minimum framework for Health Visitor contacts that require to take place. These are to take place in the home setting where development can be assessed and any parental concerns regarding the wellbeing of the child can be raised and discussed.



The details of all contacts made with the child and/or family is held in the Community Child Record (CCR). This is a paper record which is kept at the Health Visitors team's GP Practice base. The records are created by the Community Child Records Department and movements and transfers between teams and Health Boards are managed by the records department. Health Visiting teams are made up of a variety of professionals and can include nursery nurses, administration staff and links with immunisation nurses.

The Health Visiting Service across Aberdeen City has approximately 12,500 children on its caseload. The majority of children are deemed core pathway and require minimal

intervention aside from the standard visits; however some of the children can identify as vulnerable, with around 10% of children across the city being identified as 'additional' pathway clients.

In addition to the risk surrounding vacancy levels, the current paper-based Community Child Record makes it difficult to comply with the Interagency Referral Discussion (IRD) policy. At present, a significant risk exists around how Health Visitors gather the appropriate information from paper-based records within the one-hour timescale, especially where an IRD is called out of office hours e.g. public holidays, overnight etc when paper-based records at GP Practices cannot be accessed.

ACHSCP and NHSG have a corporate responsibility to support staff members who work in isolated situations. Within the NHSG Lone Working policy, support systems for checking in and monitoring are recommended for managing the risk which surrounds Lone Working and the implementation of an electronic scheduling and records management application could reduce this risk.

The Health Visiting Service can create and tap into a large sphere of information about the child. Due to the nature of paper records, this can be challenging to share with other professionals and analyse effectively. There are also significant amounts of duplication where concerns exist around siblings in the same family. It has been challenging to obtain baseline figures on the current paper-based system on which to project benefits but using Lean 6- Sigma methodology, we tapped into one process and estimated that we could save each Universal Health Visiting Pathway visit in the child's first year 16.5 minutes. Considering that 2,000 new children come into the service each year and seven visits are conducted over this first year, this would result in a saving of 3,850 hours per year for this cohort of children. Costing this time at the top of a band 7 salary plus 22.5%, this equates to £108,069 of time saved. This also does not consider other children out with the first 12 months of the Universal Care Pathway. This time saving alone, provides the potential for ACHSCP to make progress towards achieving the national Universal Health Visiting Pathway and potentially lowering the vacancy risk level by alleviating some of the pressure points on the service.

ACHSCP has identified that the procurement and roll-out of an 'off the shelf', electronic scheduling and records tool could help to mitigate these risks and increase better patient outcomes. An accelerated timescale in conjunction with increased resource has been placed on this project to ensure that progress is made quickly so that the day to day operational tasks of the Health Visiting teams can improve while reducing the need for duplication. This application is to be an interim electronic solution with a lifecycle of a maximum of five years so that the identified risk factors can be immediately addressed and reduced.

ACHSCP is aware that the Community Child Record is a NHS Grampian-wide record and that movements between the Aberdeen, Aberdeenshire and Moray Health Visiting Services occur frequently and it would be the business's hope that if a solution can be found for

ACHSCP that this could be adopted across Grampian so that the benefits could be realised by all three Health Visiting services and so that children and their care-givers can benefit from the ability to share data seamlessly. However, this is dependent upon Aberdeenshire and Moray Health and Social Care Partnership's support and agreement.

2. Objectives
Application can store and update the Community Child Record
Application provides scheduling on behalf of the Health Visiting Service
The application should be off the shelf and require no code development
The application should either • Be known to NHS Scotland • Successfully used in similar services such as child health • Or application has been used in a Health & Social Care setting
The application must be able to be used as a Mobile Application on touch screen devices compatible with one of the following • Android • IOS The system must also be compatible with Windows and Microsoft Office 365
Application to be assessed for usability within a mobile context in order to give productivity gains.
Although not mandatory, system will be assessed for enterprise scalability
Compliant with NHS Grampian Information Security and Information Governance standards
The application should provide value for money

2.1 Scoring of Options Against Objectives

Objectives	Do Nothing	NHSG Estate – TrakCare	Hybrid-Morse	Enterprise Solution-EMIS	
Application can store and update the Community Child Record	0	2	2	2	
Application provides scheduling on behalf of the Health Visiting Service	0	2	3	2	
The application should be off the shelf and require no code development	0	0	3	3	
The application should either: Be known to NHS Scotland and successfully used in similar services such as child health Or application has been used in a Health & Social Care setting	0	3	3	3	
Application to be assessed for usability within a mobile context in order to give productivity gains.	0	0	3	2	
Although not mandatory system will be assessed for enterprise scalability	0	2	2	3	
Compliant with NHSG Information Security and Information Governance Standards	0	3	2	2	
The application should provide value for money	0	2	3	2	
Total	0	14	21	17	

Ranking	4	3	1	2	

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

2.2 Recommendation

Based on the options appraisal, it is recommended that a hybrid approach is taken, and we would recommend that the procurement of the Cambric Morse system is progressed. The utilisation of Morse would allow for the service to work in a day-to-day mobile fashion regardless of network connectivity while building on the lessons learned from other Health Boards who have realised the benefits of this system already.

Based upon the work achieved in the NHS Western Isles where Morse was rolled out to one service, a conservative estimate has been made that we can expect to save the Health Visiting Service approximately five hours per week per practitioner by reducing the number of trips back to base to collect paper files. This represents 12,000 hours based on a 48-week year and would account for the equivalent of six FTE posts. This time saving is irrespective of increased productivity from pre-populated forms and more automated processes.

These may not be cashable savings but would allow the health visiting service to give a higher quality service which would in turn mean better patient outcomes.

This type of system implementation would enable progress to be made on a relatively short timescale to allow the Health Visiting Service to schedule and manage their caseload. Building on this, it would be possible to build the Community Child Record into the application utilising work and forms created by other Health Boards while allowing us to make configuration changes needed to enable it to tie in with the Health Visiting Service's needs. An interface with SCI Store would allow for the application to be furnished with demographic details and, where appropriate, information could be sent back from the Community Child Record to SCI Store. This could provide a view of data to Acute and Primary Care meaning that the circle of care around the child would be more complete.

One major benefit of this approach is the data capture in forms. It means that the business can decide upon what information is required and mandatory about each child. This in turn offers a robust means of reporting without having an additional cost attached with a vendor each time business logic or processes change.

Since this is a known solution for Health Visiting and is successfully used in other Health Boards, it is anticipated that lessons learned could be sought and that ACHSCP could take part in future user groups which would help to shape the direction of the product into the future.

As this project is seen to be an interim solution which would allow the Health Visiting Service to move onto an electronic platform, it is recommended that an initial two-year contract is entered into with the supplier, with negotiations year by year thereafter.

Also, as part of the recommendations the project team would look to initiating a project utilising Lean Sigma Six methodology to reduce administration overhead and streamline data capture and business processes.

3. Benefits

3.1 Patient Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Measure Frequency
Improved Service Delivery	Compliance of the Universal Health Visiting Pathway	Reporting	n/a	Delivery of service expectation	3 months post implementation
Improved information sharing	Perceived improvement in information sharing within and between teams	Staff Questionnaire	n/a	Improved communication	3 months post implementation

3.2 Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Measure Frequency
Improved information sharing	Perceived improvement in information sharing within and between teams	Staff Questionnaire	N/A	- Reduction in duplication of information. - Improved Information sharing across ACHSCP teams. - Productivity gains	3 months post implementation
Efficiencies from working with an electronic record	Time saving	Lean 6 Sigma review		- Improved time management - Productivity gains	6 months post implementation

Universal Health Visiting Pathway reporting	Reporting	Service Data	N/A	- Ability to conduct reporting	3 months post implementation
Reduction in the duplication of information	Perceived improvement in duplication of information, time saving	Staff Questionnaire/Lean	N/A	- Reduction in the duplication of information. - Productivity gains	3 months post implementation
Reduction in risk of current vacancy level to Health Visiting Service	Review of Risks	Risk register	N/A	- Improved Staff Morale - Productivity gains	6 months post implementation
Ability to comply to IRD requests	Compliance to 1 hour access to information where the child's record is available electronically.	IRD Spreadsheet	N/A	- Compliance to NHSG Health Attendance at IRD Policy 2019	6 months post implementation
Increased compliance to the NHSG lone working policy	Perceived increase of support from staff	Staff questionnaire	N/A	- Increased compliance to the NHSG lone working policy	3 months post implementation
CHAD dataset reporting	Reporting	Service Data	N/A	- Compliance of national reporting	3 months post implementation

3.3 Resources Benefits (financial)					
Benefit	**Measures**	**Source**	**Baseline**	**Expected Benefit**	**Measure Frequency**
Productivity gains	- Compliance with Universal Health Visiting Pathway - Lean 6 Sigma Review	- Reporting - Lean 6 Sigma Review	N/A	- Compliance with Universal Health Visiting Pathway - Time efficiency savings from reduction in duplication of information	3 months post implementation

4. Costs

Name	Description	Year 1	Year 2
Devices and Scanners	This will include: - a tablet device, - keyboard, - pencil, - 3 years insurance and - Mobile iron security software over 3 years A separate business case looking at devices is available	£89,362	
Application License and Server and	Service-based license for Health Visiting. Covers up to 600 users. Super User Training for up to 10	£120,614	£43,200

implementation Costs	individuals and Form Configuration training for up to 5 individuals included in cost.		
	Year total	**£209,976**	**£43,200**
		Total	**£253,176**

5. Time

5.1 Key Milestones

Description	Target Date
Procurement of Application	3rd September 2019
Procurement of Devices	3rd September 2019
Sign off from NHSG Information Security and Information Governance	20th September 2019
Application Hosted on NHSG Servers and accessible	1st October 2019
SCI Store Interface in place and tested	31st October 2019
Implementation of Application (Phase 1- Scheduling)	30th November 2019
Implementation of Application (Phase 2- Community Child Record)	15th January 2020
Implementation of Application (Phase 3- Reporting)	31st January 2020
Project Close/Business as Usual	29th February 2020

*Note – this is a summary version of the Business Case, the full Business Case is available on request to IJB board members.

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	03 September 2019
Report Title	Primary Care Improvement Plan (Update)
Report Number	HSCP.19.049
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	*Jenny McCann* *Transformation Programme Manager* *jmccann@aberdeencity.gov.uk* *01224 523945*
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	A. Aberdeen City Primary Care Improvement Plan Year 2

1. Purpose of the Report

1.1. The Primary Care Improvement Plan (PCIP) sets out how the Partnership intends to transform general practice services, to release capacity of General Practitioners to allow them to undertake their role as Expert Medical Generalists as set out in the new General Medical Services Contract.

1.2. The initial Primary Care Improvement Plan was approved by IJB in August 2018. An annual update of the Primary Care Improvement Plans is now required, and this report brings the updated Primary Care Improvement Plan forward for approval by the IJB.

1.3. A draft of this document has already been submitted to the Scottish Government to meet the timeline within the process as set out by the Scottish Government.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the revised Primary Care Improvement Plan as attached at Appendix A.

b) Note the identified risk around workforce and the mitigating actions that are being developed,

c) Instruct the Chief Officer to invite the Director of Workforce from NHS Grampian to provide an overview of the workforce planning they are undertaking and how this may impact on the delivery of the PCIP in Aberdeen.

3. Summary of Key Information

3.1. As reported to IJB in May 2018, the new General Medical Services (GMS) contract came into force from April 2018. This has required changes in the way the contract is delivered by practices and how the contract is monitored by both NHS Grampian and the Health and Social Care Partnership (HSCP).

3.2. Related to this new contract was the provision of transformation funding to help provide GPs with the capacity to undertake their roles as Expert Medical Generalist as set out in the new contract. Each IJB was required to set out aims and priorities for releasing GP capacity within a Primary Care Improvement Plan (PCIP).

3.3. The Aberdeen City PCIP was approved in August 2018 and sets out the aims, priorities and strategic intent for delivery of the 2018 GMS Contract in Aberdeen City from 2018-19 to 2020-21.

3.4. The plan, developed through a collaborative partnership approach, identifies priorities for the city across six pre-identified areas. These are:

- The Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professional Roles
- Community Links Practitioners

3.5. The plan is based on the seven key principles for the redesign of primary care as set out in the GMS Contract Memorandum of Understanding, to deliver services which are: safe, person-centred; equitable; outcome focused; effective; sustainable; and ensure affordability and best value.

3.6. Over the last year multi-disciplinary short-life project teams have developed each priority area, to produce more detailed proposals and business plans for how these services can be delivered in the most effective, equitable and sustainable way for primary care across Aberdeen City. Delivery of a number of these projects is now underway.

3.7. The updated PCIP sets out progress during year 1 (2018-19) and implementation plans for the next two years. The document also provides detail on planned budget allocations and an assessment of how this compares to estimated resource required to fully implement the Memorandum of Understanding (MOU). This document also seeks to demonstrate the workforce requirements (and potential challenges) in order to fully implement the MOU.

3.8. The final, updated PCIP is attached at Appendix A. A draft of this was submitted to Scottish Government at the end of July 2019 along with equivalent plans for Aberdeenshire and Moray Integration Authority areas.

3.9. To meet submission timelines, the Scottish Government requested that a "local agreement" be put in place with the GP Sub Committee with IJB sign off coming later, subject to the next available IJB meeting. The PCIP was presented to the Local Medical Committee and GP Sub Committee with provisional approval granted in August 2019. Full approval is dependent on a letter being submitted alongside the three Grampian PCIPs to Scottish Government which highlights GP Sub Committees concerns around the ability of this plan (and the plans of Aberdeenshire and Moray IJBs) to address challenges around infrastructure, IT and consumables for the new roles.

3.10. The development of this plan continues to be considered in conjunction with the Action 15 Plan, our capital build programme and the Technology Enabled Care Framework which provide clarity around the prioritisation of a number of activities, all of which contribute towards the delivery of our Strategic Plan.

3.11. The PCIP projects are currently at varying stages from business case development to implementation. In line with usual process, proposed directions will continue to be brought to IJB for approval supported by detailed business cases, and implementation progress and benefits realised

will be reported through the Audit and Performance Systems Committee to provide assurance of progress.

3.12. A local evaluation framework is being developed in order to help demonstrate the impact of the PCIP. Learning will be taken from existing projects within the PCIP that have established project specific frameworks, for example Community Link Workers.

4. Implications for IJB

4.1. Equalities

It is anticipated that the implementation of this plan will have a neutral to positive impact on the protected characteristics as detailed by the Equality Act 2010.

4.2. Financial

4.2.1 There is specific ringfenced funding available in respect of the implementation of the Primary Care Improvement Plan. A high-level summary of the available funding allocated to deliver the PCIP, actual spend for 2018/19 and an indicative expenditure profile for 2019 - 2022 is as set out below in Table 1:

Table 1: PCIP actual and forecast spend 2018-2022

	2018/19 (actuals)	***2019/20 (forecast)***	***2020/21 (forecast)***	***2021/22 (forecast)***
Vaccination Transformation Programme	62,721	181,447	236,705	242,173
Pharmocotherapy Services	321,759	580,600	835,926	1,336,650
Community Treatment and Care Services	129,000	170,400	812,267	1,589,534
Urgent Care	53,620	118,512	366,228	732,456
Additional Professional Roles	159,804	210,847	381,168	977,109
Community Link Working	451,591	730,000	811,200	843,648
Programme Support Costs & to be Allocated*		345,022	837,926	249,971

PCIP Total	**1,178,495**	**2,336,828**	**4,281,420**	**5,971,541**

**The unallocated amounts include a transfer of £150,782 in 2019/20 and £150,000 in 2020/21 and 2021/22 from Aberdeenshire HSCP to allow for the net total of Aberdeenshire residents that are registered with Aberdeen City practices (15,933).*

Note: These figures are projections based on the available information at the current time. These figures will continue to be updated as business cases are developed, and projects implemented and are therefore likely to change over time.

Financial summaries in relation to this plan are required to be submitted to the Scottish Government in October 2019. With further financial reports required to be provided to the Scottish Government bi-annually.

4.2.2 There are 16,338 Aberdeenshire residents registered with Aberdeen City practices and 405 City residents registered with Aberdeenshire practices). To allow for this total net (15,933) Aberdeenshire/ Aberdeen City cross boundary flow, an agreement has been finalised in August 2019 with Aberdeenshire HSCP that will see the transfer of £150,782 to ACHSCP for the 2019/20 financial year. A recurring allocation is expected annually, pending a review of changes in practice population.

4.2.3 The PCIP plan has been developed based on the financials listed within the plan (Appendix A) and in Table 1 above. However, if we were able to take into account the total underspend (including the amount we did not draw down from Scottish Government and the amount held in reserves) from the 2018/19 allocation, and the transfer from Aberdeenshire, the total amount available to deliver PCIP would total £2,951,000. This is represented in Table 2 below:

Table 2: Total funds available to support the delivery of PCIP in 2019/10

	Allocated in 18/19 £'000	**Received in 18/19 £'000**	**Spent in 18/19 £'000**	**Held in Reserves £'000**	**Allocated in 19/20 £'000**	**Transfer from Aberdeenshire**	**Available in 19/20 £'000***
PCIP	1,793	1,298	1,178	120	2,186	150	2,951**

** Total underspend from 18/19 = £615,000*
***Available in 2019/10 is calculated by totalling the underspend from 2018/19, the transfer from Aberdeenshire in August in 2019 and the allocation for 2019/20*

4.2.4 The Scottish Government has indicated that they will continue to fund PCIP at previously agreed levels. Whilst it is not yet confirmed, it is anticipated that as with Action 15 and ADP monies, Scottish Government will only provide the whole amount available for PCIP in 2019/20 if the spend is forecast and once reserves carried forward have been spent. It is unlikely that £2,336,828 will be fully spent in this financial year, due to appropriately qualified workforce not being available locally. The amount due from the Scottish Government will be monitored by finance colleagues and reported regularly to the IJB. Work will continue to determine how the unclaimed funds could be spent and whether it would be possible to bring forward projects from later financial years or identify new projects of a one-off nature.

4.3. Workforce

The PCIP will result in significant changes to our workforce, including additional staff and new ways of working.

Workforce has been identified as a significant risk to this workstream. There are a range of activities ongoing including mapping existing workforce available against existing services and exploring different ways of providing services that are not reliant on recruiting new members of staff.

As part of our future planning process we will identify and plan on an operational basis the specific posts that we require to deliver the PCIP and will feed this into our workforce plan and reflect this in future refreshes.

The Scottish Government has included projections for funding for future years and has advised that it should be assumed that the funding will be recurring and that workforce recruitment to deliver the plans can be progressed as permanent posts where appropriate. Business Cases take this assumption into consideration.

4.4. Legal

The PCIP seeks to provide the capacity within General Practice to support the implementation of the new GMS Contract. Any commissioning and procurement of services, required to implement the plan, has and will continue to be progressed in a compliant manner.

4.5. Other

There are no other anticipated implications as a result of this report.

INTEGRATION JOINT BOARD

5. Links to ACHSCP Strategic Plan

5.1. This plan links to the following aims as set out in our Strategic Plan:

- **Prevention**

  The PCIP is a high-level plan, looking to modernise primary and community care in Aberdeen to support and improve the health, wellbeing and quality of life of our local population.

- **Resilience**

  Activities identified in the PCIP, for example Link Practitioners have self-management at their core. The PCIP states an aim to ensure patients are better informed how to manage their long term-conditions using technology enabled care.

- **Personalisation**
  The provision of the additional professional roles such as MSK First Contact Practitioner, Community Chaplaincy Listeners and Activities within the PCIP will help to ensure that the right care is provided in the right place and at the right time when people are in need.

- **Connections**

  Activities in the PCIP such as Link Workers, and support in using digital technologies will help support people, make meaningful connections and relationships to promote better inclusion, health and wellbeing.

- **Communities**

  Again, activities identified in the PCIP, such as the introduction of Link Practitioners, will help strengthen and signpost to existing community assets.

6. Management of Risk

6.1. Identified risks(s)

Workforce: There is a risk that the workforce required to deliver the aims that are the subject of this report may not be available. This risk will be

mitigated through ongoing engagement with key stakeholders and the ongoing refinement of implementation proposals to deliver the plans.

Infrastructure: There is a risk that we lack infrastructure to enable new ways of working set out within the PCIP (i.e. building space/ICT). There are a number of live projects in the Capital Programme progressing through the 3 stage Business Case process to the Scottish Government. Work is underway to develop an Infrastructure Plan by early 2020 to ensure we have identified the priorities for future investment in infrastructure (i.e. buildings, ICT, equipment and transport links) to enable integration and the delivery of new ways of working at a City and Locality level. The risk will be further mitigated by ensuring a more aligned planning approach across Community Planning to maximise capital investment opportunities to best achieve the PCIP objectives.

Financial: The risk of not approving the PCIP may result in the loss of funding to the partnership as set out in the financial implications of this report.

6.2. Link to risks on strategic or operational risk register:

- Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery
- There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend

6.3. How might the content of this report impact or mitigate these risks:

The PCIP sets out ACHSCP's intentions in relation to releasing capacity of General Practitioners will which help mitigate the workforce risks as outlined in the strategic risk register. Furthermore, approving the PCIP will help ACHSCP make use of the additional funding to address these issues.

Approvals	
Sandra Ross	Sandra Ross (Chief Officer)

INTEGRATION JOINT BOARD

	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN CITY PRIMARY CARE IMPROVEMENT PLAN UPDATE 2019/20

20 MAY 2019

1. Introduction

The Aberdeen City HSCP Primary Care Improvement Plan (PCIP) set out the aims, priorities and strategic intent for delivery of the 2018 General Medical Services (GMS) Contract in Aberdeen City from 2018-19 to 2020-21.

This was based on the 7 key principles for the redesign of primary care as set out in the GMS Contract Memorandum of Understanding, to deliver services which are: safe, person-centred; equitable; outcome focused; effective; sustainable; and ensure affordability and best value.[i] .

The purpose of this document is to set out progress during year 1 (2018-19) and plans for the next two years. This document also provides detail on planned budget allocations and also an assessment of how this compares to estimated resource required to fully implement the Memorandum of Understanding (MOU). This document also seeks to demonstrate the workforce requirements (and potential difficulties) in order to fully implement the MOU.

2. Purpose

In line with guidance issued by the Scottish Government[ii] from the national GMS Oversight Group, the aims of this plan are:

1. To describe the progress achieved in 2018-19 towards delivery of Aberdeen City's PCIP.

2. To set out expected progress and objectives for 2019-20, to be agreed with the local GP Sub-Committee and Aberdeen City Integration Joint Board (IJB).

3. To provide updated workforce and expenditure projections providing assurance as to progress towards recruitment to primary care multi-disciplinary teams.

3. Summary of Progress in 2018-19

3.1 Organisational and Governance Arrangements

The Aberdeen City PCIP described the high-level actions and initial proposals for service delivery models for each of the 6 priority areas agreed nationally.[iii] Over the last year multi-disciplinary short-life working groups have led on each priority area, linking with NHS Grampian and national groups, to produce more detailed proposals for how these services can be delivered in the most effective, equitable and sustainable way for primary care across Aberdeen City.

The GMS City Implementation Leadership Group has provided strategic clinical oversight of the PCIP ensuring linkages to our GP Practice clusters via the Clinical Leadership structure. Modernising Primary and Community Care is also a key transformation programme of work driving operational delivery of the HSCP's strategic priorities.

The Aberdeen City HSCP Senior Management Team, comprising clinical, managerial, and professional leads, has provided governance and accountability with respect to decision-making and allocation of resource aligned to the PCIP. The HSCP has engaged with and updated the Integration Joint Board and GP Sub Committee as implementation has progressed.

Engagement has taken place with local GPs and Practice Managers through a variety of methods including practice visits, update events and involvement in development workshops for key priority projects. A dedicated workshop in March 2019 was used to report and discuss progress with local implementation of the PCIP. A follow-up workshop is planned for later in the year.

The GP Cluster Quality Leads are strongly encouraged to discuss the PCIP at their local meetings with Practices.

A communication plan for engagement with the public moving forward is in development.

3.2 Learning from Year 1

Considerable progress has been made during 2018-19 to deliver key objectives of the Aberdeen City PCIP, allowing for flexibility whilst ensuring adherence to the core aims and principles of the new contract. A key challenge has been to develop a model which is responsive to the significant variation across our 29 GP Practices in terms of size, population need/demographics, local systems and practice. In tandem with that, practices have been given opportunities to prioritise what projects and initiatives would make most difference to the practice itself.

Our approach has sought to build on the many strengths within primary care in Aberdeen City whilst being aware of potential risks, recognising the existing good outcomes for patients, and the need to ensure that outcomes must be maintained or improved through delivery of new services. Sustainability of General Practice has also been a priority - workforce pressures, in particular GP recruitment/retention, have continued to present significant challenges in Aberdeen City reflecting the national position.

The HSCP has also sought to maintain a whole system approach rather than the development of isolated services. This includes maintaining and further developing the well-established relationships and arrangements within our existing primary care teams.

3.3 Key changes from previous PCIP

- Amalgamation of Locality Diagnostic Hubs, Phlebotomy and Community Hubs (scope practice phlebotomy demand to inform allocation of extra phlebotomy time)
- Removal of Practice Aligned Care Management and Silver City as stand-alone headings – linked to Multi-Disciplinary Teams (MDT) membership inputting into MDT approaches.
- Removal of Integrated Triage as a stand-alone project – there are a number of barriers to the use of integrated triage (employment and IT issues when being considered across practices) and therefore it is felt that initiatives such as Workflow Optimisation (which may allow cross working between practices in due course), triaging of workload to additional professional roles within the practice and MDT

working are more appropriate and effective projects to concentrate our resources on.

3.4 Overarching risks

- Infrastructure: challenges with providing accommodation for new staff in practices and across communities. This risk will be mitigated by working with partners and key stakeholders to investigate sustainable options to work differently to best achieve the PCIP objectives.
- Workforce: challenges around availability, recruitment, ongoing training and management of staff. This risk will be mitigated through ongoing engagement with key stakeholders and the ongoing refinement of implementation proposals to deliver the plans.
- Practices have their own preferences/ priorities/ timelines. This risk will be mitigated by working with and consulting practices on the ever evolving development of PCIP and its delivery.
- Delays in the drawdown of financial resources. This risk will be mitigated through robust financial planning.

Table 1: Aberdeen City HSCP Primary Care Implementation Plan Review and Forward Planner

MOU 1 – Vaccinations			
Vaccinations			
18/19 Update	19/20 Planned Activity	20/21 Planned activity	Resource (Finance & People)
The following Vaccinations elements are resolved and now in place: • BCG administered at birth for 'at risk' babies • Pertussis for pregnant Women • School Vaccinations Team National guidance on Travel Vaccines central to progression of this area.	Transfer of responsibility for: • Pre-school Immunisations • Pre-school Flu • Flu for pregnant women Work progressing on a partnership approach across Grampian to agree Vaccinations model for region.	• Shingles • Pneumococcal • Adult Flu • At risk • Travel The delivery of vaccinations will be undertaken within a community hub model.	**Proposed allocation** 18/19: 104,776 | 19/20: 181,447 | 20/21: 236,705 | 21/22: 242,173 **Spend** 18/19: 62,721 | 19/20 | 20/21 | 21/22 **No. of Employees / FTE** Year: 18/19 – Number: 2 **Potential Cost of full MOU delivery** Scoping Ongoing – will join with Community Treatment and Care (CTAC) Services below for additional allocations **Potential No. of Employees / FTE of full MOU delivery** Scoping Ongoing – will join with CTAC below for additional allocations

General Comments	Issues experienced	Risks going forward	Additional narrative on costing of full MOU delivery
N/A	Difficulty in getting part-solution business cases approved through different governance structures (for example, transfer of pregnancy vaccinations to Midwives).	Cost is still uncertain. Model for delivery of Travel Vaccines requires national guidance which has yet to be given.	Above is an estimate of staffing levels to deliver Pre-natal and Pre-school vaccinations. Equipment costs to be determined once model and locations have been agreed. Additional immunisations capacity to be allocated to CTAC Hubs

MOU 2 – Pharmacotherapy Services			
Pharmacotherapy			
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
All practices now receive a small amount of additional pharmacist input, in addition to the original 'core' pharmacy hours (approx. total of 2 days per week per practice)	Currently, Proposed Allocation for 19/20 is fully recruited to for Pharmacotherapy Services workstream. Confidence that any additional allocation could be recruited to by year end.	If further funding allocation made available to the Pharmacotherapy workstream: • Recruitment to pharmacy & technician posts (as funding / availability of staff allows • Continuation of planned activity / managing risks etc as outlined for 19/20 • Further work with the existing pharmacy team and with practices to determine optimum deployment of staff across the HSCP	**Proposed Allocation (*21/22 Staff model based on 1:10000 rather than 1:5000)** 18/19: 410,000 | 19/20: 512,083 | 20/21: 835,926 | 21/22: 1,336,650 **Spend** 18/19: 321,759 | 19/20: [redacted] | 20/21: [redacted] | 21/22: [redacted] **No. of Employees / FTE** Year: 18/19 | [redacted]: 10.1 WTE **Potential Cost of full MOU delivery at 21/22 (based on 1:5000 model)** £2,673,300 - **£1,336,650 shortfall** **No. of Employees / FTE to fulfil MOU** Year: 21/22 | No.: Unknown – to be developed | FTE: 63.5 (see below) | [redacted]

General Comments	Issues experienced	Risks going forward	Additional narrative on costing of full MOU delivery
Planning ongoing by Pharmacotherapy Teams around the service that can be provided within the allocated resource. Lead Pharmacists will arrange to visit all practices over the next few months to discuss expectations. Regardless of available financial resources, it will take time to train and develop new members of the Pharmacotherapy Team.		**Financial:** There is a risk that the funding made available by Scottish Government (SG) to HSCPs for primary care transformation and therefore the funding allocated by HSCPs to pharmacotherapy stream of GMS will be insufficient to adequately resource a sustainable quality service. **Workforce availability:** Availability of registered pharmacy technicians and pharmacists will not meet the estimated staffing requirement. A new model is also required for pharmacy technician training. This cannot be carried out solely in primary care as	As recommended by the NHS Grampian Pharmacotherapy Services Group, costings estimated for 1WTE per 5000 patients. An additional 25% to be added to cover for planned & unplanned leave (Annual leave, sick leave, maternity leave). This model (including the appropriate skill mix) to be worked up in detail, however, based on 60/40 pharmacist /technician split and a 65/35 Band 7/Band 8a split for pharmacists, this would equate to an additional:

There is a particular issue with training pharmacy technicians, as this cannot be done solely in the primary care setting. Pharmacy technicians working in GP practices is a new role / concept for ACHSCP. Currently technicians are deployed in areas where we see their skills are best utilised (support to patients and carers (formal & informal) in their own homes or intermediate care or other homely settings) Practices are all independent contractors, however in order to provide a Pharmacotherapy service for the whole HSCP (& to support cover for leave) there will need to be an element of consistency between the way practices work in relation to the core areas outlined in the contract. Need to ensure that indemnity cover is in place for all members of the pharmacotherapy team (as NHS G / HSCP employees).		this sector cannot provide all the necessary experience / standards of training required. Recruitment of pharmacy teams (pharmacists and technicians) is already having an impact on hospital and community pharmacy staffing with potential for destabilisation of service delivery across secondary care & community services. **Workforce development capacity:** The current training, support and mentoring capacity within the managed pharmacy service and GP practices will not be adequate to meet staff development needs. There is a very limited availability of pharmacists who are already qualified as Independent Prescribers, so this will have to be factored into development time. **Signing prescriptions:** There is a gap in expectation between the national GP representative narrative and Pharmacy, that Pharmacotherapy teams will sign all prescriptions. The prevailing view within pharmacy teams is that the focus should be on improving systems of review and authorisation but without an implicit commitment to pharmacists signing all resulting prescriptions **Management capacity:** Introduction of significant numbers of new staff to current small HSCP pharmacy team will require a review of management and professional leadership capacity to provide appropriate support, performance management and professional assurance **Impact on current level 2 and 3 services** Resourcing and prioritisation of Level 1 services may put at risk sustainability of current Level 2 and 3 services. **Infrastructure:** Lack of Physical space for teams within practices. All opportunities arising from investment in infrastructure will maximised to enable colocation.	Band 8a x 10.7WTE £703,354 Band 7 x 12.8WTE £692,813 Band 5 x 20.3WTE £742,473 £2,138,640 With additional 25% allowance for annual leave, sickness, maternity £2,673,300 Further consideration still needs to be given to the following: • Role of current ‘core’ pharmacy team (4WTE pharmacists, 1.5WTE technicians) • Requirement for additional time for experienced staff for tutoring (Foundation / Advanced VT, Independent Prescribing) & mentoring new, less experienced staff. • Additional management time (team size will significantly increase)

		IT infrastructure and access to clinical systems will be required.	

Workflow Optimisation			
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
This is a training project to optimise internal information flow processes. No ongoing IT costs. This has been proven to reduce GP workload elsewhere. Business case developed and approved by IJB in December 2018, and put out to tender in January 2019. Bids considered and preferred provider appointed to train and implement model across all practices.	Initial introductory training sessions complete (April 19). Full roll out (in progress) will be complete within 6-12 months, with ongoing support from provider for 24months.	Business as usual for practices.	**Proposed Allocation** 18/19 | 19/20 | 20/21 | 21/22 0 | 68,517 | 0 | 0 **Spend** 18/19 | 19/20 | 20/21 | 21/22 0 | [redacted] **Potential Cost of full MOU delivery at 21/22** Within allocated resource **No. of Employees / FTE** Not applicable for this workstream

General Comments	**Issues experienced**	**Risks going forward**	**Additional narrative on costing of full MOU delivery**
N/A	IT challenges	Ongoing staffing costs for individual practices may restrict them rolling out fully	N/A

MOU 3 – Community Treatment and Care Services			
Self-management and Collaborative Care			
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
House of Care (HoC) Three practices recruited (beginning of 2018) for HoC cohort one. One of these practices went live in 18/19. Four signed up for cohort 3 (March 2019) Increased Use of Telecare and Telehealth – further development required	Cohort 3 of HoC sees 4 practices to begin training - two practices in April 2019, with a further two in May 2019. Increased Use of Telecare and Telehealth – further development required	Future Cohorts in development Increased Use of Telecare and Telehealth – further development required	**Proposed Allocation** 18/19: 15,000 | 19/20: 40,000 | 20/21: 35,000 | 21/22: 35,000 **Spend** 18/19: 0 | 19/20: [redacted] | 20/21: [redacted] **Potential Cost of full MOU delivery at 21/22** Within allocated resource **No. of Employees / FTE** Year | No. | FTE 18/19 | TBC | TBC 19/20 | TBC | TBC 20/21 | TBC | TBC

General Comments	Issues experienced	Risks going forward	Additional narrative on costing of full MOU delivery
N/A	N/A	Sustainability of HoC model going forward within practices – effect on nursing and administrator time of longer annual appointment and sharing of clinical information with patient ahead of this	N/A

Locality Diagnostic Hubs / Phlebotomy / Integrated Community Health & Care Hubs			
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
Scoping of need and demand	Project Team identified and	Scale-up of planned model.	**Proposed Allocation**

completed in addition to different models of delivery Practices visited and spoken to about phlebotomy. Scoped potential sites with room availability for community health and care hubs. Services to be delivered: • Biometrics (height, weight, BP) • Chronic Disease Monitoring (inc. Bloods) • Phlebotomy • Minor Injuries and dressings • Ear syringing • Suture Removal • Minor Surgery (some types)	established. Aim to have phlebotomy resource provided to practices to utilise, upskill and train phlebotomy staff in advance of moving to community health and care hubs (CHCH). Capital Projects will provide an opportunity to locate services in integrated Community Health and Care Hubs. The development of the HSCP Infrastructure Plan will ensure a City wide and Locality approach to the development of building, ICT, equipment and transport links to enable integration and colocation. Hubs will be based on a skill mix of B5 registered nurse, B3 HCSW and higher banded Immunisations Nurses Scoping has identified 7 possible existing locations – further modelling required. Two modelling workshops planned for July/ September 2019 which will agree model to be implemented	(Envisaged that modelling workshops will identify a city-wide model that will be tailored / tweaked to match local needs.)	18/19 | 19/20 | 20/21 | 21/22 40,000 | 130,400 | 777,267 | 1,554,534 **Spend** 18/19 | 19/20 | 20/21 | 21/22 0 | [redacted] **Potential Cost of full MOU delivery at 21/22** Within allocated resource **No. of Employees / FTE** Year | No. | FTE 19/20 | 5 | 5 20.21 | 20 | 19.5 21/22 | 39 | 39

General Comments	Issues experienced	Risks going forward	Additional narrative on costing of full MOU delivery
N/A	N/A	Inability to Recruit Availability of Physical Space	Year 21/22 - 6 Band 7 staff (£366,228); 3 band 6 staff (£155,382); 3 band 5 staff (£124,881); 24 B3 treatment / phlebotomy resource (£705,240); 3 B4 administrator (£97,803)

			Consumables budget £105,000 per year from 2021/22 onwards. *Note additional nursing resource to be inputted also completing Immunisations workload and supervising lower banded workers through Hub model.

MOU 4 – Urgent Care			
Unscheduled Visiting Service			
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
Advanced Nurse Practitioner (ANP) currently operating afternoon visiting service covering 8 GP practices.	As part of Unscheduled Care project this will be spread further to become scaled up to city-wide in 20/21. Demand modelled on current 'West Visits' Service. Adverts out presently for other Unscheduled Practitioners	Scale-up to city-wide by end of 20/21. Linkages with Acute Care at home which has a budget of £675,000 to a skill-mixed team to assess and treat patients in their own home.	**Proposed Allocation** 18/19 | 19/20 | 20/21 | 21/22 88,814 | 118,512 | 366,228 | 732,456 **Spend** 18/19 | 19/20 | 20/21 | 21/22 53,620 | [redacted] **Potential Cost of full MOU delivery at 21/22** Within allocated resource **No. of Employees / FTE** Year | No. | FTE | [redacted] 20/21 | 6 | 6 21/22 | 12 | 12

General Comments	**Issues experienced**	**Risks going forward**	**Additional narrative on costing of full MOU delivery**
N/A	N/A	Ability to recruit workforce	Based on 6x B7 Urgent Care Practitioners in 20/21 and 12x B7 Urgent Care Practitioners in 21/22

MOU 5 – Additional Professional Roles

<table>
<tr><th colspan="5">Community Mental Health</th></tr>
<tr><td>18/19 Update</td><td>19/20 Planned Activity</td><td>20/21 Planned Activity</td><td colspan="2">Resource (Finance & People)</td></tr>
<tr><td rowspan="15">From 2018, from the excellent results of the pilot a permanent service was put into place. There continues to be a high demand for this service. The demand on the service is predominately 21-35 age range with a majority of those presenting problems of depressions, general anxiety or panic disorders.
The service is delivered in 3 tiers:-
Tier 1 – Mild to moderate mental health problem characterised by distress but with limited effect on functioning.
Tier 2 – Moderate Mental Health problem that is unlikely to improve without specialist therapy but does not prevent date to day functioning
Tier 3 – Complex mental health problem that is most likely longstanding and recurrent that significantly impairs the quality of life and some functions</td><td rowspan="15">Due to the current high demand. The service is looking to develop the model and increase capacity to support tier 2 individuals (mild-moderate) using Psychological well-being practitioners or equivalent type posts.

In addition, there is also some consideration for additional support at tier 3 with 2 additional psychological therapists.

Both these developments are currently at Outline Business Case stage and are going to the Action 15 Project Group for approval to take forward, or not.</td><td rowspan="15">Business as Usual</td><td colspan="2">Proposed Allocation (Note – PCIP contributes a small portion funding to Psychological Therapy service – Action 15 is main funding source)</td></tr>
<tr><td>18/19</td><td>19/20</td><td>20/21</td><td>21/22</td></tr>
<tr><td>204,337 (53% of total from PCIP)</td><td>110,847 (20% of total from PCIP)</td><td>131,168 (25% of total from PCIP)</td><td>102,109 (14% of total from PCIP)</td></tr>
<tr><td colspan="4">Spend</td></tr>
<tr><td>18/19</td><td>19/20</td><td>20/21</td><td>21/22</td></tr>
<tr><td>116,668</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Potential Cost of full MOU delivery at 21/22</td></tr>
<tr><td colspan="4">Within allocated resource</td></tr>
<tr><td colspan="4">No. of Employees / FTE</td></tr>
<tr><td>Year</td><td colspan="2">No.</td><td>FTE</td></tr>
<tr><td>18/19</td><td colspan="2">12.86</td><td>12.86</td></tr>
<tr><td>19/20</td><td colspan="2">13+6 should developments be approved</td><td>13+6 should developments be approved</td></tr>
<tr><td>20/21</td><td colspan="2">13+6 should developments be approved</td><td>13+6 should developments be approved</td></tr>
<tr><td>General Comments</td><td>Issues experienced</td><td>Risks going forward</td><td colspan="2">Additional narrative on costing of full MOU delivery</td></tr>
<tr><td>The Psychological Therapies service is not an urgent service and therefore referrals are taken in date order for equity, with the exception veterans who receive priority as per SG directives.</td><td>Waiting lists are a challenge with a large demand on the service. Current striving towards a target of 18 weeks. However only 60% of practices are under that target at present. For clinical/counselling psychology this is currently waiting lists of up to 6months (providing Tier 1 interventions for moderate mental health problems).</td><td>The service has received good feedback and is meeting the needs however it is recognised that demand is on the increase and therefore waiting times will increase. Work is underway to look at further development of the service (see above).

Accommodation issues could restrict location of delivery.</td><td colspan="2">Within Allocation – bulk of funding comes from Action 15 monies.

Note – Plans to expand service in development through Action 15 (potential additional Clinical Psychotherapist roles and introduction of B5 roles).</td></tr>
<tr><td colspan="5">Community Listening Service</td></tr>
</table>

18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
11 GP Practices in Aberdeen City have Community Chaplaincy Listeners (CCLs). All other practices can refer into sessions held at Aberdeen Health Village/ ARI or Woodend Hospital) Approval by ACHSCP IJB on 26th March to appoint Community Listening Service Coordinator (CCLSC)- P/T 0.5FTE in year 1 and 2 increasing to 1 FTE in year 3 and 4 to support growth in programme 5 additional interested practices with capacity	Recruit Community Listening Service Coordinator (Interviews scheduled for June 2019) Work with project team to develop reporting a evaluation framework Develop and implement volunteer recruitment, training and retention plan	Continue spread of service across interested practices in Aberdeen City	**Proposed Allocation** 18/19: 22,700 | 19/20: 48,100 | 20/21: 54,114 | 21/22: 59,013 *This funding comes entirely from Action 15 – not PCIP **Spend** 18/19: 0 | 19/20: [redacted] | 20/21: [redacted] | 21/22 **Potential Cost of full MOU delivery at 21/22** No cost to PCIP **No. of Employees / FTE** Year | No. | FTE 18/19 | 1 + vols | 1 19/20 | 1 + vols | 1 20/21 | 1 + vols | 1

General Comments	Issues experienced:	Risks going forward	Additional narrative on costing of full MOU delivery
N/A	N/A	Inability to recruit CCLSC and volunteers Lack of buy in from GP practices Lack of space in practices to host CCLs	Funded from Action 15 monies

MSK First Contact Practitioner (FCP)

18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)
Appointment to temporary Band 8a post to start work around FCP Physio in Aberdeen. This was to deliver FCP physio role in one practice in the south of the city and to provide capacity for city wide implementation planning work. This will be used to inform the model for a phased role out across the city.	To consolidate the Band 8a post into a permanent post (63K). Plan to appoint Band 7 for 8 months of this year (35K). To roll this out to one other practice and to look at how this skill mix will deliver the FCP role which in turn will inform the wider scale up across the city.	Further scale up across the city – final skill mix of 8a/7 still to be determined at this stage	**Proposed Allocation** 18/19: 84,825 | 19/20: 100,000 | 20/21: 250,000 | 21/22: 875,000 **Spend** 18/19: 42,489 | 19/20: [redacted] | 20/21: [redacted] | 21/22 **Potential Cost of full MOU delivery at 21/22** 875,000 **No. of Employees / FTE**

			Year	No.	FTE	[redacted]
			18/19	1	1	
			19/20	2	2	
			20/21	5	5	
			21/22	15	15	

General Comments	Issues experienced	Risks going forward	Additional narrative on costing of full MOU delivery
N/A	A pragmatic choice was made to the practice chosen. There was a necessity for rapid implementation due to challenges in one practice. The post was made on a temp basis to allow this to happen. This impacted the ability to forward plan for this service with resultant challenges for example access to IT systems, data gathering and Imaging.	Managing practices expectation relating to the phasing of the funding over the 4 years. Recruitment to these posts. Lag in training and development to deliver the full FCP model. Availability of demand data to inform accurate capacity planning. Accommodation issues could restrict location of delivery. Clarity around what FCP skills are required for what grade	Within Allocation Modelling completed on basis that clinical staff can telephone / see 25 patients per day. Pilot of service currently underway – first 6months of data suggests modelling is robust. This will be monitored as service expands and skill mix widens. Modelling based on city practice 8,800 practice population - appointment numbers using multiplier for City-wide figs. Assumption that 25% of all current GP appointments will be appropriate for MSK FCP. Modelling includes 25% additional capacity for 52-week cover (Annual leave cover, etc.)

MOU 6 – Community Link Practitioners						
Community Link Practitioners						
18/19 Update	19/20 Planned Activity	20/21 Planned Activity	Resource (Finance & People)			
All 29 GP Practices in Aberdeen City have been allocated a LP following a phased roll out of the Aberdeen Links Service - phase 1 in July 2018 and phase 2 in March 2019. We currently have 19 Link Practitioners in post (17.65 FTE)	Second phase practices will to start making referrals to the service as of 1st April 2019 Ongoing recruitment to ensure full complement of LPs in place (20.8FTE)	Business as Usual	**Proposed Allocation**			
			18/19	19/20	20/21	21/22
			730,000	780,000	811,200	843,648
			Spend			
			18/19	19/20	20/21	21/22
			451,174	[redacted]		
			Potential Cost of full MOU delivery at 21/22			

Overall buy in to the service has been strong across first of phase practices, with 761 referrals received up to 31/03/19. Most common reasons for referral are mental health (188), social isolation (135) and finance and benefits (131).	Complete 6-month service evaluation and use to inform continued service development Take steps towards embedding the "Links Approach" across Primary Care Test the placement of a Link Practitioner within a custody suite setting		Within allocated resource **No. of Employees / FTE** Year / No. / FTE 18/19 / 18 / 18 19/20 / 22 / 20.8 20/21 / 22 / 20.8

General Comments	**Issues experienced**	**Risks going forward**	**Additional narrative on costing of full MOU delivery**
N/A	Challenges around information governance between multiple parties Recruitment of Link Practitioners within original timescales	Information Governance Retention of Link Practitioners	Within Allocation

4. Finance and Workforce Projections

In setting out the financial and workforce plan for year 2 of the PCIP it is important to acknowledge the potential risks in implementing such significant change over a relatively short time frame. Aberdeen City HSCP would identify the following as the priority areas of risk:

- The level of available funding is insufficient to implement all services as described within the new contract.

- Our ability to recruit and retain staff to new roles is hindered by lack of available workforce.

Whilst in these initial stages we are seeing a positive level of interest and successful appointments to many posts under the PCIP, this is against a backdrop of historic difficulties in recruiting to a number of disciplines. Meeting the workforce projections set out may prove very challenging. Neighbouring IJBs will also be recruiting to many similar posts. Many of these roles may require additional training and this will impact on developments. There is also a need to ensure that we do not destabilise other areas of our system during this transition stage.

Table 2 below provides current indicative figures on expenditure against the PCIP over the next 3 years.

Full Implementation Cost represents estimated funding required to fully implement all services as described under the new contract (desirable, as indicated by particular services).

There is a need to maintain some flexibility around implementation depending on availability of workforce and other factors. In turn this will enable the HSCP, where appropriate and in agreement with key stakeholders, to make decisions within years to allow some developments to progress more quickly than others.

Figures are indicative at this stage and will change as plans continue to develop.

It should be noted that underspends and ‘Unallocated’ budget line have been offered to both MSK FCP and Pharmacotherapy projects to bring forward recruitment timelines should the project teams feel they can do this. Plans being worked up presently.

Table 2: Aberdeen City PCIP Indicative Expenditure Profile, 2019 - 2022

Priority Area	2019/20	2020/21	2021/22	Current Spending Plan		Potential Full Implementation Cost	
				Cost (£)	Workforce	Cost (£)	Workforce
Vaccinations	181,447	236,705	242,173	242,173	Current indicative figure for pre-natal and pre-school, planned to link all other immunisations with CTAC services	Within planned resource	Current indicative figure, additional allocation for other immunisations within CTAC services
Pharmacotherapy Services *Pharmacotherapy* *Workflow Optimisation*	580,600 *512,083* *68,517*	835,926 *835,926* *0*	1,336,650 *1,336,6500* *0*	1,336,650 *1,336,650* *0*	1:10,000 model – exact skill mix tbc Costings based on 50% of Potential Full Implementation (1:5000)	1:5000 model = £2,673,300 **£1,336,650 shortfall**	* WTE/skill mix to be agreed - indicatively: Band 8a x 10.7WTE Band 7 x 12.8WTE Band 5 x 20.3WTE
Community treatment and care services *House of Care (HoC)* *Locality Diagnostic Hubs/ Integrated Community Health & Care Hubs*	170,400 *40,00* *130,400*	812,267 *35,000* *777,267*	1,589,534 *35,000* *1,554,534*	1,589,534 *35,000* *1,554,534*	6 Band 7 staff; 3 band 6 staff; 3 band 5 staff; 24 B3 treatment / phlebotomy resource; 3 B4 administrator (including £105,000 consumables p/yr)	Within planned resource	Within planned resource – allows for skills mix and for qualified nurses to supervise staff and also deliver immunisations
Urgent care	118,512	366,228	732,456	732,456	Based on 6x B7 Urgent Care Practitioners in 20/21 and 12x B7 Urgent Care Practitioners in 21/22	Within planned resource	Within planned resource – planned link with Acute Care at Home (Rapid Assessment element) ACHSCP funded budget of £675,000 allocated,
Additional professional roles *Community Mental Health*	210,847 *110,847* *100,000*	381,168 *131,168* *250,000*	977,109 *102,109* *875,000*	977,109 *102,109* *875,000*	Circa 15 WTE Physiotherapists with skill mix to be agreed 1 WTE Community Listening Co-ordinator	Within planned resource	Within planned resource

MSK First Contact Practitioner							
Community Link Working	730,000	811,200	843,648	843,648	20.8 WTE Link Practitioners	Within planned resource	Within planned resource
Programme Support Costs & to be Allocated*	345,022	837,926	249,971	99,971			
Total	**2,336,828**	**4,281,420**	**5,971,541**	**5,821,541**			

*The unallocated amounts include a transfer of £150,782 in 2019/20 and £150,000 in 2020/21 and 2021/22 from Aberdeenshire HSCP to allow for the net total of Aberdeenshire residents that are registered with Aberdeen City practices (15,933).

References

[i] Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – GMS Contract Implementation in the context of Primary Care Service Redesign.

[ii] *Primary Care Improvement Plan Reporting Cycles* (18 February 2019), Correspondence from Richard Foggo, Head of Primary Care, Scottish Government.

[iii] British Medical Association / Scottish Government (2017) *The 2018 General Medical Services Contract in Scotland.*

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	Transformation - Decisions Required: Action 15
Report Number	HSCP.19.053
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Karen Gunn Head of Mental Health karen.gunn2@nhs.net
Consultation Checklist Completed	Yes
Directions Required	Yes
Appendices	a. Primary Care Psychological Wellbeing Business Case Summary b. Primary Care Psychological Wellbeing Direction to NHSG c. Mental Wellbeing Out of Hours Business Case Summary d. Mental Wellbeing Out of Hours Direction to ACC

1. Purpose of the Report

1.1. This is one of three transformation reports seeking approval to agree financial expenditure to progress a number of projects which support the delivery of our Strategic Plan.

1.2. The purpose of this report is to request approval from the IJB to incur expenditure, and for the Board to make Directions to NHS Grampian and Aberdeen City Council, in relation to projects that sit within the Action 15 programme plan which has previously been approved by the IJB.

1.3. The projects relate to strategic intentions and are delivering key areas of change.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board (IJB):

a) Approve the expenditure, as set out in Appendix A, relating to the Primary Care Psychological Wellbeing project.

b) Instruct the Chief Officer to issue the Direction to NHS Grampian relating to the Primary Care Psychological Wellbeing project as per Appendix B.

c) Approve the expenditure, as set out in the Business Case at Appendix C relating to the Mental Wellbeing Out of Hours project.

d) Instruct the Chief Officer to issue the direction relating to the Mental Wellbeing Out of Hours project as per Appendix D to Aberdeen City Council and NHS Grampian.

3. Summary of Key Information

3.1 The National Mental Health Strategy 2017-2027 identified 40 national action points under 5 headings:

1. Prevention and early intervention;
2. Access to treatment, and joined up accessible services;
3. The physical wellbeing of people with mental health problems;
4. Rights, information use, and planning;
5. Data and measurement.

3.2 Action 15 is about access to joined-up accessible services, entailing whole system change: “Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.”

3.3 It is important to ensure appropriate alignment between the national direction and local priorities. Action 15 fits well with the wider Mental Health & Learning Disabilities Review in terms of sustainability. It also fits well with

the local Community Mental Health Delivery Plan (currently out for wider consultation) in terms of the local objectives, which include: developing support in the community which promotes independence and self-management; ensuring strong links between services and good transitions in care between different components of the pathway. This work also forms part of, and supports delivery of, the Primary Care Implementation Plan.

3.4 Scottish Ministers commissioned the Health & Justice Collaboration Improvement Board to consider how Action 15 might best be delivered and the following principles were developed:

- The additional services be commensurate with the national commitment,
- The nature of the additional capacity be very broad ranging,
- Improvements might include the provision of services through digital platforms or telephone support; and
- Improvement may include development for staff who are not currently working in the field of mental health.

3.5 In terms of the four key settings identified by the national commitment, two of these, namely Police Custody Suites and HMP Grampian are 'hosted' by Aberdeenshire IJB. Equity of access, regardless of City or Shire residence is however, seen as a must. Consequently, there has been good linkage with Aberdeenshire colleagues and efforts to identify fair funding splits in these joint settings, based on average numbers (the details of these are captured in the proposals set out in appendices A and C).

Primary Care Psychological Wellbeing

3.9 This project will see the scaling up of the Primary Care Psychological Therapy service which has been in place in Aberdeen since 2018. The service provides clinically effective evidence-based psychological treatment for those suffering from mild to moderate common mental health issues such as anxiety disorders and depression.

3.10 This business case proposes to complement the existing service by establishing four Psychological Wellbeing Practitioner (PWP) posts offering Tier 1 high volume, brief treatment packages consisting of 1-2-1 guided self-help and group-work based therapy. The enhanced service will be available during the day and in the evenings to maximise flexibility and access.

Mental Wellbeing Out of Hours

3.11 The purpose of this project is to provide an alternative to the existing specialist pathway for those individuals who are experiencing mental health distress and who come to the attention of Police Scotland and the Custody Suite at Kittybrewster or who present to the Accident and Emergency Department (A&E) at Aberdeen Royal Infirmary (ARI). The custody suites are hosted by Aberdeenshire and used by offenders and patients who are mainly from Aberdeen and Aberdeenshire. The A&E Department will see patients from both authority areas.

3.12 Development of this project has been progressed in partnership with colleagues from Aberdeenshire Health and Social Care Partnership.

3.13 The project will run for an initial 23-month period and will test a solution to fill an identified gap in the current mental health pathway.

4. Implications for IJB

4.1 Equalities

Inequality, mental health and human rights are inextricably linked. These proposals will ensure mental health services are accessible and meet the needs of all in compliance with Equality legislation. An Equality Impacts Assessment of the finalised strategy will be completed prior to submission for approval in November 2018.

4.2 Fairer Scotland Duty

4.3 Financial

The recommendations in this report will result in financial expenditure from the Action 15 fund. Full details of the financial implications are contained in the associated business cases.

4.4 Workforce

Action 15 of the National Mental Health Strategy commits to providing an additional 800 Mental Health Workers in Scotland (Aberdeen City's share is approximately 36) over the next 5 years and this will result in the recruitment and development of supplementary staff, who will support local services.

4.5 Legal

Procurement for services will use recognised good practice and comply with legal requirements.

4.6 Other

None

5. Links to ACHSCP Strategic Plan

5.1 The recommendations in this report seek to deliver aspects of the Action 15 Plan, and there are clear links to the wider strategic plan including supporting and improving the health, prevention, wellbeing and quality of life of our local population, and supporting our staff to deliver high quality services that have a positive impact on personal experiences on outcomes.

6. Management of Risk

6.1 **Identified risks(s)**

A shift in the balance of care requires to be carefully planned, implemented and evaluation to ensure continued stability of the system to meet needs. Implementation of these proposals will be underpinned by a risk management framework.

Risks relating to the Transformation Programme are managed throughout the transformation development and implementation processes. The Executive Programme Board and portfolio Programme Boards have a key role to ensure that these risks are identified and appropriately managed.

6.2 **Link to risks on strategic or operational risk register:**
The main risk relates to not achieving the transformation that we aspire to, and therefore our ability to sustain the delivery of our statutory services

within the funding available. The resultant risk is that the Integration Joint Board fails to deliver against the strategic plan.

Risk 2. There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend

Risk 5. "There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet performance standards or outcomes as set by regulatory bodies."

Risk 9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

6.3 How might the content of this report impact or mitigate these risks:

By ensuring that all proposals are developed in consultation with partners, experts by experience and carers, the IJB ensures these services are relevant and meet the needs of people who experience poor mental health.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

	Business Case	Project Stage **Define**

Project Name	Primary Care Psychological Wellbeing Practitioners	**Date**	20/08/2019
Project Manager/ Author	Susie Downie Transformation Programme Manager	**Date of Programme Boards/ IJB**	IJB 03/09 EPB 14/08

Contents

1. Business Need

Strategic Alignment
This development is in line with the ACHSCP Strategic plan priorities of,

- Person centred care, whereby the right care is received at the right time and right place
- Resilience, providing patients with skills to manage their mental health to enable people to cope with the challenges they face.

The proposed model would also facilitate delivery of the Scottish Mental Health Strategy model of "Ask Once Get Help Fast" (Scottish Government, 2017)

The scaling up of this service is identified as a priority within both the Primary Care Improvement Plan and the Action 15 Plan. The service will work closely with the Link Practitioners (as referenced in the PCIP) and wider third sector tiered support for people in distress, to provide an effective interface between physical health and mental health services.

Background
The Primary Care Psychological Therapy Service has been a permanent service within Aberdeen City since 2018 providing clinically effective (Battersby 2017, Spry 2018) evidence-based psychological treatment for those suffering from mild to moderate common mental health issues such as anxiety disorders and depression (Tier 2 & Tier 3 – see appendix 1). Prior to this a limited service was available from the 1.8 wte Doing Well By Depression team. The two services have amalgamated and now a high-quality evidence based psychological therapies service consisting of 10 posts covering Tier 2 (mild-moderate) and 2 posts covering Tier 3 (moderate mental health needs) is available to cater for the large numbers of people (1807 referred in 2018) requiring the service across the city.

A Psychological Therapist is based in each GP practice in Aberdeen city for varying amounts of time ranging from 1 to 5 half day sessions per week. At the moment GP's refer patients they feel would benefit from the service directly to the service. It is not possible to self-refer and it is unlikely that this will change going forward as the GP needs to make the clinical judgement as to whether or not the patient is suitable for the service. Patients are then assessed by the Psychological Therapist and are either placed on their waiting list or passed on to the Clinical Psychologists who see patients with moderate mental health difficulties (Tier 3)

This business case proposes to complement the existing service by establishing 4 Psychological Wellbeing Practitioner (PWP) posts offering Tier 1 high volume, brief treatment packages consisting of 1-2-1 guided self-help and group-work based therapy.

These posts aim to provide core evidence-based treatment in line with clinical treatment guidelines (NICE, the Scottish Matrix) for Tier 1 (mild) mental health problems which are diagnosable within clinical diagnostic frameworks such as ICD-10**,** or symptoms which present as a precursor to clinically diagnosable conditions, in order to prevent their progress to more serious mental health problems. At present no comparable service exists within Aberdeen City and so the needs of this patient group remain largely unmet, or are met less appropriately within higher tiered services. Referrals to this new service will be made via the GP, from other tiers of the PT Service, Link Practitioners or as a self-referral. Secondly, the role would provide clinical input for patients who are currently accessing Beating the Blues computerised CBT. There is substantial evidence that rates of engagement with the programme and clinical outcomes are significantly improved by such input. (Richardson & Richardson 2012, Palmqvist 2007).

It is proposed that the service will be available during the day and in the evenings to provide maximum flexibility and access. Links will be made with communities to utilise existing resources to deliver the group work.

This proposal looks to open and enhance referral pathways in order to ensure seamless service for those patients requiring onward referral (as appropriate) to other services. This frees up clinical and administrative time and speeds up the process.

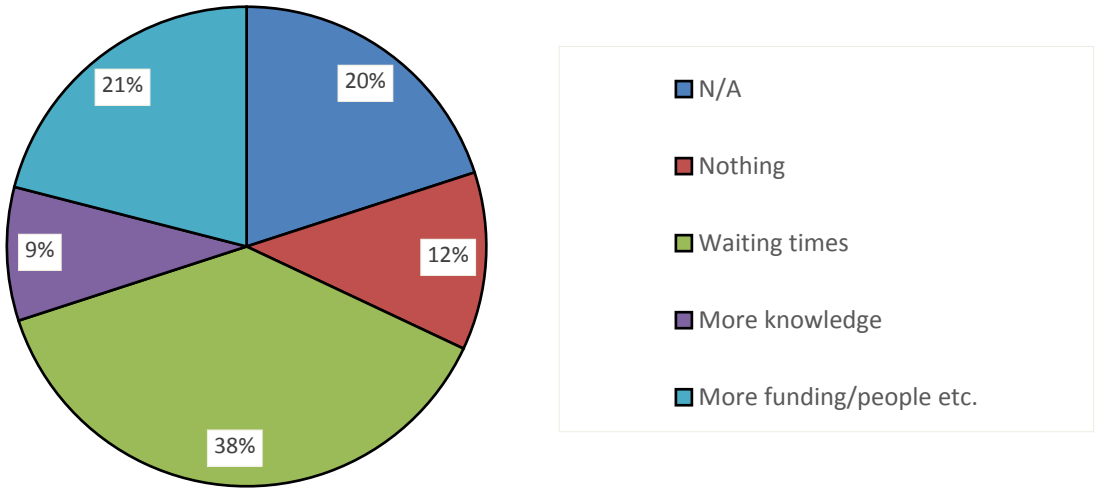
The additional workforce will include people who are degree-qualified however do not require specific formal mental health qualifications and experience. Training and supervision will need to be provided, thus bringing a much needed new pool of candidates into the workforce. Recent recruitment to these posts in the Aberdeenshire primary care psychological therapies service received 58 applicants of whom 26 were selected for interview and 11 recruited to 9wte posts.

Relevant Data

In the calendar year 2018, the Tier 2 service received 1807 referrals. The waiting time for first appointment of assessment and treatment in December 2018 ranged from 3 to 46 weeks. In June 2019 the waiting times ranged from 2 (new surgery) to 49 weeks, with 44% of GP surgeries not meeting the SG HEAT target of 18 weeks from referral to treatment.

An analysis of the Patient and GP experience surveys carried out by two Career Ready interns recently highlights that 18% of patients felt that having to wait 6 – 12 months for an appointment was too long. In addition the highest percentage of responses (38%) from the GP's to the question "Do you have any suggestions about how we can improve the service" cited waiting times as in issue. 21% of GP's also stated "more funding/people etc." as a way to improve the service. Therefore 59% of GP's surveyed felt that the service would benefit from additional resource to reduce waiting times.

3.) Do you have any suggestions about how we can improve the service?



An audit of cases since the service database began in January 2017 has shown that 9% of cases referred to the service have depression and anxiety scores which would place them in the mild category demonstrating that they would be appropriate for treatment at Tier 1. This does appear low, however GP's do not currently refer patients suitable for Tier 1 as they are below the threshold for the Tier 2 service and therefore this figure is not surprising as it does not present a complete picture of the demand. Should the Tier 1 service exist, GP's and patients would be able to refer/self-refer, therefore reducing waiting times for the Tier 2 service, resulting in people receiving help sooner. In addition the workload of GP's would be reduced, which is one of the primary aims of the new GMS Contract, as the Tier 1 patients that they are currently seeing would be referred to the PWP's.

There is a large body of evidence from other areas of the UK that Improved Access to Psychological Therapies (IAPT) services, all of which include Band 5 PWPs, as to the benefits of this role. The most recent review from IAPT (IAPT NHS Digital 2019) shows that of the 49,389 cases treated in 2018/19, 52.9 % moved to recovery (that is, moved from having clinically significant symptoms to no longer having these symptoms) following treatment within IAPT services, more than 50% of whom have been seen by PWPs

Evidence suggests nine out of 10 adults with mental health problems are supported in primary care and broadening the range of services means local health services are better equipped to deal with patients' physical and mental health needs (NHS England, 2018).The evidence suggests that one in six people will be diagnosed as having depression or chronic anxiety disorder at any given moment, and one in three families will be affected (Psychiatric Morbidity Survey).

If this is looked at in terms of the population of Aberdeen, there are 190,985 over 16's in Aberdeen city (www.aberdeencity.gov.uk). If the prediction is 1 in 6, this equates to 31,837 people who will have a diagnosis as having depression or chronic anxiety disorder. The

prediction is that 15% of those will seek psychological therapy which in the Aberdeen context will mean 4775 people will be seeking treatment from the existing service per year. With current staffing levels, this equates to 397 cases per Psychological Therapist per year.

In addition, a clinical audit has shown that patients receiving treatment through the evidence based Primary Care Psychological Therapies Service within Aberdeen City improved significantly in terms of symptoms of both depression and anxiety following treatment (Battersby 2017, Spry 2018).

Positive Impact
In addition to reducing pressure on GPs, and the Tier 2 psychological therapy service and in completing the tiered model, this service will ultimately reduce the pressure on secondary care mental health services. The effect of the service to date on secondary care services is evidenced by the reduction in referrals to adult mental health Psychology at Royal Cornhill Hospital with a corresponding reduction in waiting times for that service. Over 80 fewer referrals were received in 2018 compared with 2016 as many patients are now seen by the Tier 3 Psychologists working in primary care in line with the ethos of “right person, right place.”

Grampian continues to have some of the lowest levels of psychological therapists in post compared with the rest of Scotland (ISD 2018) (see Appendix 2) and this expansion of the current PT service would go some way to addressing this. Appendix 2 shows that Grampian psychology services have a WTE of just over 11 per 100,000 population compared with the Scottish average of just under 16. This places Grampian the second lowest of all mainland Boards.

In terms of patient outcomes we would see reductions in anxiety disorders and depression which have been evidenced in other areas using the PWP service model (NHS Digital 2019). There is substantial evidence that such interventions lead to reduction in healthcare usage overall including reductions in repeat prescriptions, GP appointments, in outpatient procedures, inpatient bed days and benefits & sick pay (Layard 2006)

Stakeholder Engagement
A stakeholder workshop was held on 7th August with representatives from statutory services and third & independent organisations. (attendees are included in section 20) The purpose of the workshop was to discuss the options outlined in previous versions of this plan and to discuss the risks, advantages and disadvantages. This was done in a world café open discussion format to allow for honest discussion and debate. It was positively received and the scoring of the options from the day has been included.

Following very interesting discussions it was decided by those present that the options should be distilled to 3 (see section 3 below). The group were then asked to individually blind score the options using the objectives below. Other relevant representatives were also asked to score the options to ensure a balanced view was captured.

2. Objectives
To improve individual mental health and wellbeing through timely access to appropriate services by offering high volume, rapid access treatment and support options.
To meet the currently unmet demand for Tier 1 services thereby reducing Tier 2 waiting times.
To reduce pressure on primary care and GP practices by having a dedicated team to deliver Tier 1 interventions locally in a primary care setting.
To continue to deliver the most appropriate and effective form of evidence-based treatment for patients with mild mental health problems, contributing to the achievement of the 18-week HEAT standard.
To provide an efficient, cost-effective service that meets the needs of the population of Aberdeen.
To complete a seamless suite of treatment options from Tier 1 to Tier 3 within primary care.
To contribute to the national commitment to increase the number of mental health workers in Scotland by 800 over the next five years.
To overcome typically encountered problems with recruitment and retention within mental health services in order to provide a sustainable service
To meet the requirements of the timescales of Action 15 of the SG Mental Health Strategy
To contribute to partnership working and the achievement of ACHSCP's strategic plan and integration aims.

3. Options Appraisal

3.1. Option 1 – Status Quo - There is no financial impact of this option, however, by not expanding the service there will be unmet patient needs.

3.2. Option 2 - To permanently fund the resourcing of a city-wide service to provide group work psychological therapy via statutory sector – Staff would be employed on permanent contracts adding to the establishment ACHSCP.

3.3. Option 3 - To externally commission third/independent sector to employ PWPs who are embedded into the current psychological therapies service.

4. Options Scoring

Objectives		Option 1	Option 2	Option 3
1	To improve individual mental health and wellbeing through timely access to appropriate services by offering high volume, rapid access support and treatment options.	-1	3	3
2	To meet the currently unmet demand for Tier 1 services thereby reducing Tier 2 waiting times	-1	2	2
3	To reduce pressure on primary care and GP practices by having a dedicated team to deliver Tier 1 interventions locally in a primary care setting.	-1	3	3
4	To continue to deliver the most appropriate and effective form of evidence-based treatment for patients with mild mental health problems, contributing to the achievement of the 18-week HEAT standard.	0	3	3
5	To provide an efficient, cost-effective service that meets the needs of the population of Aberdeen	-1	1	3
6	To complete a seamless suite of treatment options from Tier 1 to Tier 3 within primary care	-1	3	2
7	To contribute to the national commitment to increase the number of mental health workers in Scotland by 800 over the next five years.	-1	3	3
8	To overcome typically encountered problems with recruitment and retention within mental health services in order to provide a sustainable service	0	2	3
9	To meet the requirements of the timescales of Action 15 of the SG Mental Health Strategy	-1	3	3
10	To ensure delivery of integration and partnership working via the strategic plan aims	0	0	3

	Totals	-7	23	28
	Rank	**3**	**2**	**1**

Scoring
Fully Delivers = 3; Mostly Delivers = 2; Delivers to a Limited Extent = 1; Does not Deliver = 0; Will have a negative impact on objective = -1

4.1. Recommendation

Following the workshop and the scoring process, Option 3 is the preferred option: **Commissioning third/independent sector to deliver Tier 1 embedded into the current psychological therapies service**.

While the service will be commissioned, work will need to be done to devise a framework with regard to how the successful third/independent sector organisation and the existing Psychological Therapies service will dovetail, how training will be delivered and supervision of staff provided through existing Partnership resources. Data sharing protocols do exist for the Link Practitioners and these could be used/adapted for this element of the service also.

The total annual costs are estimated to be:

Year 1: £171,297;

Year 2: £170,135

Year 3-4: an option of a further 2 years to extend (projection based on year 1-2 costings)

Total cost for approval for 4 years: **£691,429**

5. Benefits

5.1. Citizen Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Reduced symptomatology & psychological distress and improved functioning in those treated by the service	Depression	PHQ 9	Scored on initial Assessment	Improved scores	On discharge	Per patient
	Anxiety	GAD 7	Scored on initial Assessment	Improved scores	On discharge	Per patient
	Impaired social and occupational functioning	Work & Social Adjustment Scale	Scored on initial Assessment	Improved scores	On discharge	Per patient
Shorter waiting times	Average waiting time from referral to commencement of treatment.	Service data	Current wait times	Wait times reduced	12 months post imp.	6 monthly

5.2. Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Less pressure on 3 GP time	GP consultation type	Vision/Emis	Current	Reduced MH consults	At 12 mths	Annually

Less pressure on Tier 2 within the primary care psychological therapies service	Referral rates	Inhouse database	Tier 2 = 1807 referrals in 2018	Reduced waiting times at Tier 2	At 12 months	Can be tracked monthly

5.3. Resources Benefits (financial)

Benefit	Measures	Source	Capital or Revenue?	Baseline (£'000)	Saving (£'000)	Expected Date	Measure Frequency
Reduced medication following treatment	Prescribed medicines	Service data	Rev	TBC	TBC	Per discharged patient	Per discharged patient
To reduce demand on higher tier services.	TBA						
	TBA						
	TBA						

6. Costs

6.1. Project Revenue Expenditure & Income

The total contract cost Is to provide a 4WTE Psychological Wellbeing Practitioner posts for Aberdeen City.

^Estimate as will be dependent on contract value.

7. Key Risks	
Description	**Mitigation**
Workforce availability for recruitment (we know from recent Shire recruitment that this workforce is readily available however may destabilise market)	This is an acceptable risk due to ensuring increase market facilitation and to attract new pool of individuals into the workforce.
There are time pressures to spend appropriate funds and ensure projects and staff are delivered on time.	Working to tight deadlines and ensuring project management and commissioning capacity will be crucial. Discussions with Scottish Government have ensured funds will be made available on the basis of approved business cases.
Risk to patients in terms of unnecessary deterioration and resulting disability associated with potentially long delays whilst the commissioning process is undertaken.	As above.
Risk to staff retention if more favourable terms & conditions are available in other areas for similar posts.	This risk is system wide.
The training required is supplied by NHS Education for Scotland (NES). They have indicated that 3rd Sector would take lower priority than NHS if a request is made for training but would be able to give this training. This option requires agreement and further discussion about training and supervision in order to enable it to happen using the best resources available to the partnership.	NES colleagues are working towards integration and therefore we will work with colleagues and give early warning of requirements to ensure the appropriate training is provided in a timely manner.
Training and supervision could be delivered as part of the job roles of those already in the primary care delivery team, or from specialists with an interest in supporting these areas. However this is a risk in terms of impacting current capacity.	The risk to not supporting these roles is greater. There will be a short-term impact for a long term gain in terms of stemming demands on the services and that referrals are dealt with by the most appropriate person.
Whilst it is not anticipated that the entire predicted numbers of people seeking assistance for mental health issues will utilise this service, there is a risk that the service could become overwhelmed	Appropriate caseloads will be agreed in line with relevant guidelines

8. Time

8.1. Time Constraints & Aspirations

After IJB approval, the procurement process will take around 4 months to complete. It is therefore anticipated to have a contact in place by January 2020 and service operational by early 2020.

After this the project would run for 2 years with a potential extension of a further 3 years. It would be agreed that service testing and development should run through the course of the project to ensure outcomes are best met.

8.2. Key Milestones

Description	Target Date
Programme Board approval	July-August 2019
IJB Approval	3 Sept 2019
Tendering process begins	Nov 2019
Contract in place	Jan 2020
Service operational	Apr 2020
Evaluation	Ongoing

*Note – this is a summary version of the Business Case, the full Business Case is available on request to IJB board members.

Appendix 1

Problem Tier

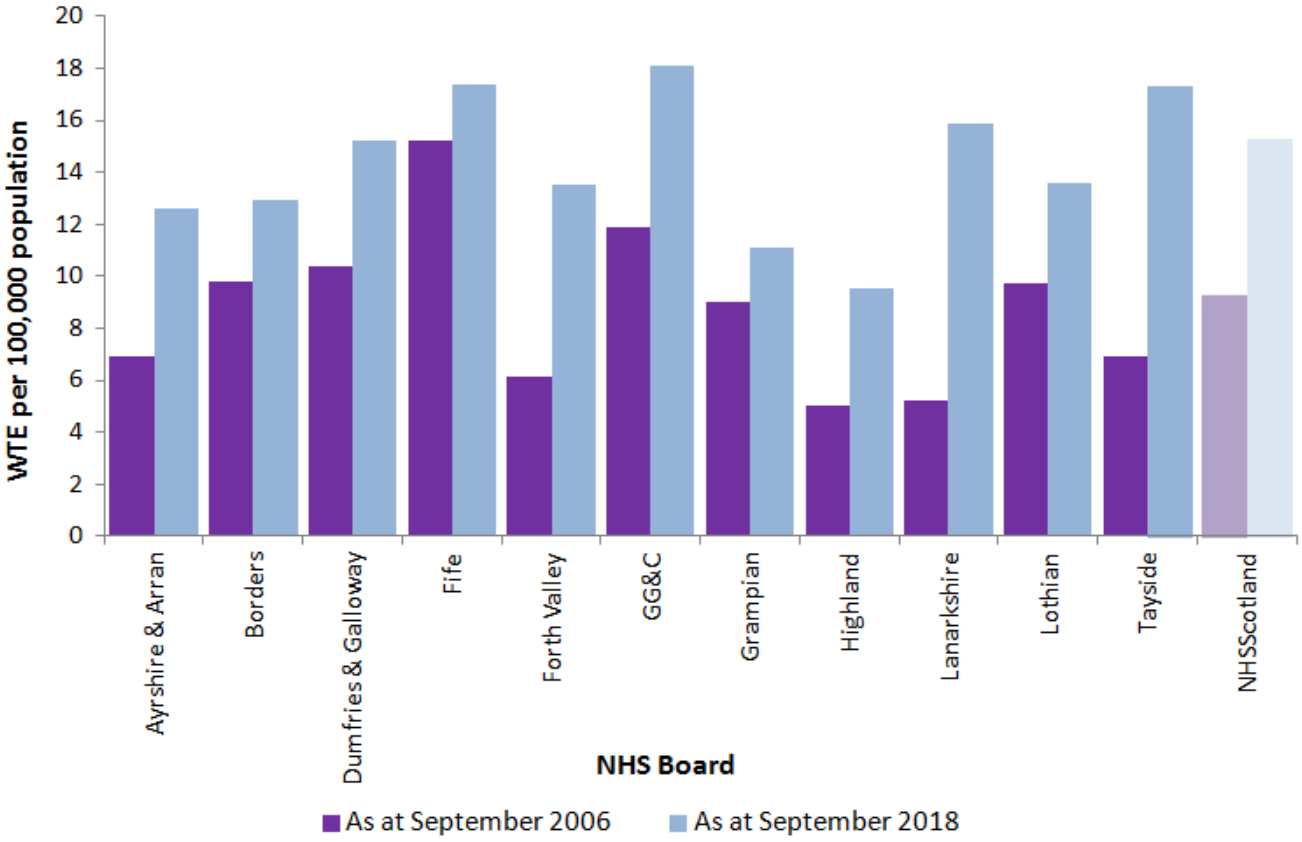
The Northumberland Tiered approach to Psychological Therapies is being developed and proving useful for the delivery of Psychological Therapies in NHS Grampian.

Within the Northumberland model problems are categorised into one of four tiers (see diagram).

Service Example	Problem Tier	Case Examples
Interagency team approach, possible inpatient care, psychosocial interventions, ongoing care as required.	**Tier 4**: Severe mental health problem with significant impairment of functioning and acute unstable, or at high risk	Acute schizophrenia, Borderline PD with high risk, severe mood disorders, severe eating disorders
Psychotherapy and/or drug therapy from appropriately trained professional plus liaison with other agencies as required. Long-term or episodic care. If not treatable at time of referral, advice on management plus support to primary care with the option to re-refer	**Tier 3:** Complex mental health problem that is most likely longstanding and recurrent that significantly impairs the quality of life and some functions.	Severe OCD, more stable schizophrenia, personality disorder (eg Dependent PD, Avoidant PD etc) Hx of physical, sexual or emotional abuse
Specific evidence-based therapy provided by appropriately trained mental health professional. Short-to-medium-term intervention. Group intervention. Medication	**Tier 2:** Moderate mental health problem that unlikely to improve without specialist therapy but does not prevent day-to-day functioning.	Moderate depression and anxiety states. Panic Disorder, phobias etc.
Support and/or counselling from appropriately trained members of the PGT, self-help materials, appropriate medication prescribed by GP, referral to voluntary sector, referral to appropriately rained counsellor, self-help groups, walk-in stress clinic	**Tier 1**: Mid to moderate mental health problem characterised by distress but with limited effect on functioning .	Reactions to life events, mild to moderate anxiety and depression, simple grief reaction, relationship difficulties not of a chronic nature or related to more complex problems.

Appendix 2

Applied Psychologists in Mainland NHS Boards. Change in WTE rates per 100,000 population between 31st March 2006 and 30thSeptember 2018 (ISD 2018)



Appendix 3

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INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

The **NHS GRAMPIAN** is hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below**.**

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.201958

Approval from IJB received on:- 3 September 2019

Description of services/functions:-

1. **Provision of Psychological Wellbeing Practitioners**

Provision of 4 Psychological Wellbeing Practitioner (PWP) posts offering Tier 1 high volume, brief treatment packages consisting of 1-2-1 guided self-help and group-work based therapy.

Reference to the integration scheme:- Annex 1
Part 2:
7. Mental health services provided in a hospital, except secure forensic mental health services.
16. Services providing primary medical services to patients during the out-of-hours.

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

The provision of this hub closely with all 5 strategic aims for ACHSCP: prevention; resilience; enabling; connections; and communities. In particular it looks to have early intervention and prevention for those in distress.

Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

Timescales involved:-

Start date:- 3 September 2019.
End date:- April 2022 (dependent on successful tender & recruitment)

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

Associated Costs

The costs for the commissioning for two years four Psychological Wellbeing Practitioner (PWP) posts offering Tier 1 high volume, brief treatment packages consisting of 1-2-1 guided self-help and group-work based therapy.

	Year 1	Year 2	*+ 1 year extension projection*	*+ 1 year extension projection*	Total
Total	£171,297	£170,135	*£173,356*	*£176,642*	£691,429

2-year contract	£341,431
Total cost	£691,429

Details of funding source:- Scottish Government Action 15 Funding

Availability:- Confirmed

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

	Full Business Case	Project Stage **Define**

Project Name	Mental Wellbeing Out-Of-Hours Hub (Accident and Emergency Department and Kittybrewster Custody Suite)	**Date**	22/08/2019
Project Manager/ Author	Susie Downie Transformation Programme Manager	**Date of Programme Boards/ IJB**	IJB 03.09.19

Contents

1. Summary of Project

The purpose is to provide an alternative to the existing specialist pathway for those individuals who are experiencing mental health distress and who come to the attention of Police Scotland and the Custody Suite at Kittybrewster or who present to the A&E Dept. at ARI.

The custody suites are hosted by Aberdeenshire and used by offenders and patients who are mainly from Aberdeen/Aberdeenshire. The A&E Department will see patients from both authority areas.

Therefore, the service model has been developed jointly and will be implemented and evaluated jointly. The model will require a percentage funding agreement from Aberdeenshire HSCP based upon activity information (anticipated c34% Shire, c66% Aberdeen City).

Tests of change are an evidence-based approach to service improvement and we believe it is important to ensure that a methodologically sound process of review underpins this project as it is developed.

The project will run for a 23 month period, and will test a solution to fill an identified gap within the current pathway by employing an out-of-hours mental wellbeing team to engage in a timely and compassionate conversation with those individuals who come to the attention of the first response services. The data examined over a 6-month period shows that 66% of attendances occurred between the hours of 1700-0900 and that 36% of all contact with A&E occurred during the weekend. The target group are individuals who are expressing feelings of intense distress and behaving in a manner which causes concern to themselves and or others.

Local data indicates that the majority of the target group do not require clinical or statutory services but do require some form of intervention to assist them manage their feelings of distress. See next section for details.

The intervention of choice will be a supportive, non- judgemental conversation with the aim of enabling people to develop their personal resilience, learn adaptive coping skills and form meaningful connections within their community and experience improved mental wellbeing.

The out of hours mental wellbeing team will primarily use a telephone triage approach and will have the option to develop additional digital methods of engagement.

There will be a requirement for the team to work in a peripatetic manner when need is identified, e.g. after initial phone call triage, however, the team will also provide a ‘safe place’ for assessment, de-escalation and compassionate conversation.

The project has parallels with the ‘No Wrong Door’ approach (Lushley *et al*, 2017), seeking to promote the development of the hub model of service provision and has included learning

from new models of service delivery across Scotland e.g. the Community Triage Service in Tayside, Distress Brief Intervention pilot, NHS24 pilot.

The team will require a physical location and it is proposed that Kittybrewster Custody Suite would be able to host them. Whilst this project is primarily focused on enhancing the current pathway by providing a lower tiered level of response, this alternative model will contribute to a much needed cultural change and begin to encourage citizens to develop the knowledge and skills required to enhance their personal resilience.

Risk & Governance

The team will utilise a validated Mental Health Triage Scale to determine risk factors and will have access to the existing first response services and associated medical pathways as and when required.

Although the team will not provide a clinical service there will be times when they will need to seek specialist advice in order to ensure oversight of risk and the escalation of any concerns. The Unscheduled Care Team at Royal Cornhill Hospital (RCH), the Custody Suite Health Care Team and the GMed service will be available to provide decision support to ensure the team is not working in isolation and that they are supported to ensure that individuals who contact the service are not exposed to risk of harm.

Joint Training and sharing of learning

A cross sector multi-agency approach to training and sharing of learning will be adopted to reinforce an integrated workforce and thereby ensuring a cohesive response to those presenting in distress.

The training would be delivered by local authority, specialist mental health colleagues and 3rd Sector partners. The option to use National Education Scotland's training packages would be explored.

Linkages to current services and the community

The team will work alongside current pathway providers in order to deliver a de-medicalised and/or de-criminalised route into timely and compassionate support. (see appendix 1 for proposed OOHs pathway).

The team will develop strong links with the primary care 'safe space' proposals and link practitioner programmes. They will work closely with first response colleagues and develop collegiate relationships with the out of hours health and social work teams.

The team will bridge an identified gap out of hours within the range of tier 1 and 2 provision available to individuals who have poor mental wellbeing or who struggle to cope with periods of heightened emotional distress.

The team will complement developments coming on stream from the associated Action 15 plans, Link Practitioners within Primary Care and the Link Worker ADA provision within the Custody Suites. This will contribute towards a necessary cultural shift from symptom management to early intervention and prevention and de-medicalisation of distress.

2. Business Need

The Scottish Government Mental Health Strategy has committed to increase the mental health workforce by an additional 800 workers within key settings (A&E, Custody Suites, GPs, Prisons) in order to increase access to appropriate mental health support as early as possible. This project will improve access to workers within those key settings.

The project aims to enable a cohort of people who currently come to the attention of the first response services and Custody Suite to manage their conditions through the provision of a responsive, compassionate response to those individuals who do not require specialist mental health services. The project will provide an alternative to custody and will increase diversion from prosecution and the criminalisation of individuals who seek assistance from first response services at times of intense distress.

Strategic Alignment

The project will contribute to the following aims of the strategic plan:

- Prevention - to shift the balance of care away from the historic models of current mental health provision within Aberdeen City by providing an out of hours response for those in distress.
- Early intervention – for those in distress and provision of a compassionate response to de-escalate where possible or to ensure appropriate signposting to services.

The development of a de-medicalised model will require a philosophical shift in thinking, not only from current service providers and partners, but also for individuals with lived experience. The team will provide a timely opportunity for people to engage in a supportive, non- judgemental conversation with the aim of enabling people to develop their personal resilience, learn adaptive coping skills and form meaningful connections within their community and experience improved mental wellbeing.

Local Data:

Service areas provided the group with data for analysis in order to:

- quantify the demand on services
- describe the cohort of individuals that the service would engage with
- demonstrate the identified need versus current service provision
- determine the parameters for the new service
- specify the knowledge, training and skill set required to fill the gap

Emergency Department

We know that the experience of people who attend A&E is often one of waiting longer than the four-hour target for assessment, and in an environment which is not conducive to enhancing their emotional wellbeing. Our rationale is based upon informed conversations with our A&E partners and our plan is to redirect people away from the A&E Department.

We expect to see a reduction in attendances at A&E by people from our target cohort by 10% at end of year one and by 25% by end of year two. This will free up specialist capacity at the A&E department and also reduce the considerable periods of time spent by police officers at the A&E department.

A four week snap-shot of attendances at A&E for patients who presented with “mental health/self harm crisis” revealed approximately 360 hours of patient contact with an average length of stay of 3 hours. Police were present with patients for approximately 15% of the time. Of the patients who attended, 62% did not require a medical intervention and 28% did not require psychiatric review. Of the total number who attended, 88% went home at the conclusion of the episode of care.

The data shows that 66% of attendances occurred between the hours of 1700-0900 and that 36% of all contact with A&E occurred during the weekend.

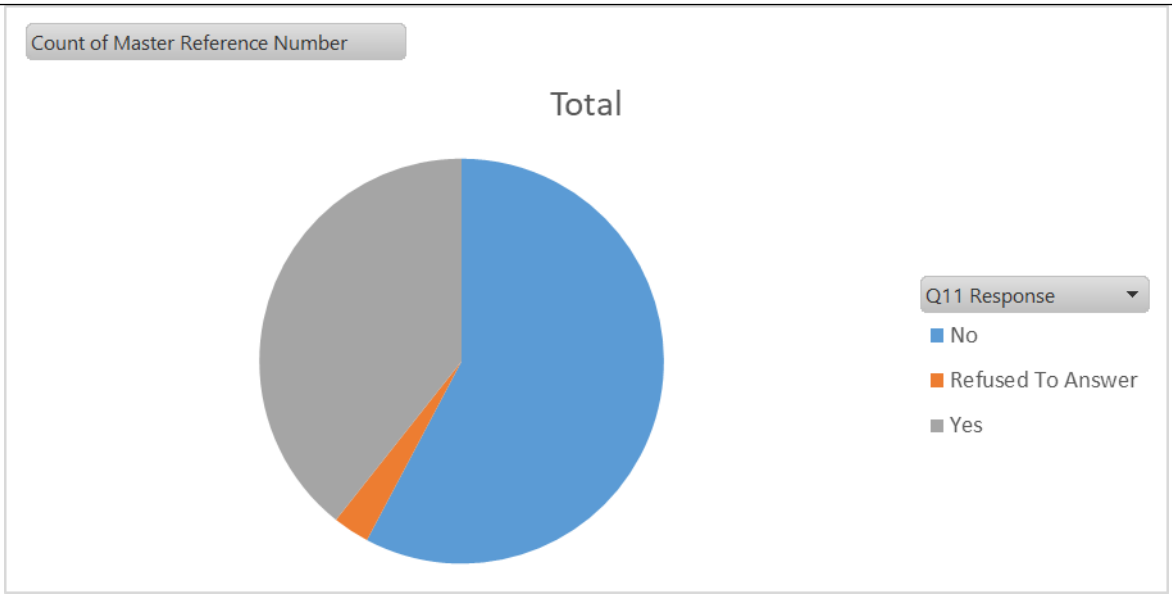
It appears that the requirement for specialist intervention following assessment at A&E is not indicated for a considerable number of patients. Anecdotal information indicates that patients who are discharged from the department are medically fit for discharge but the feeling from staff is that a compassionate response to people in distress would be humane, reduce attendance at the department and associated specialist time and reduce the likelihood of repeat visits.

It is notable that 9% of patients required in-patient treatment at RCH following assessment at A&E. It is important to ensure that the project maintains this established pathway for those patients who require specialist psychiatric intervention/treatment.

Custody

The 2017 publication ‘Justice in Scotland: Vision and Priorities’ noted that 39% of those detained in police custody have a mental health disorder.

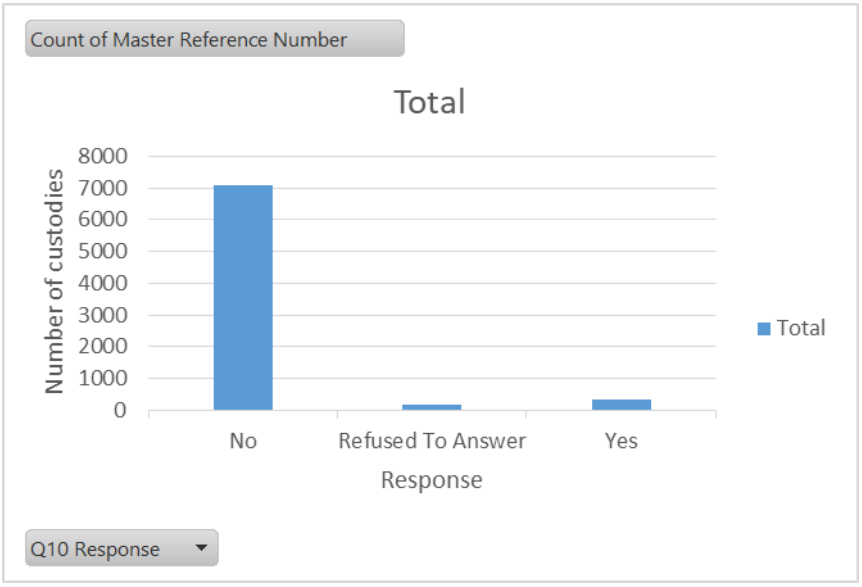
The Kittybrewster Custody Suite has a throughput/ footfall of approximately 7600 people per year (80% male, 20% female) and the chart below shows local responses to the question “Do you have any mental health problems or have you ever received treatment for mental health problems?”



The local figures mirror the national average of those detained in custody disclosing that they have had or are currently experiencing issues with their mental wellbeing.

The question asked at the point of entry into custody is extremely broad ranging. Anecdotal information provided by the custody health care manager would suggest that specialist intervention was not indicated for the majority of our local detainees.

The following table shows the response to the more focused question, “Do you have any thoughts at present of self harm/suicide?”



This represents approximately 8% of those detained in custody disclosing current thoughts of self harm/suicide. Therefore, similar to A&E, it is important to ensure that the project

maintains the established pathway for those in custody who do require specialist psychiatric intervention/treatment.

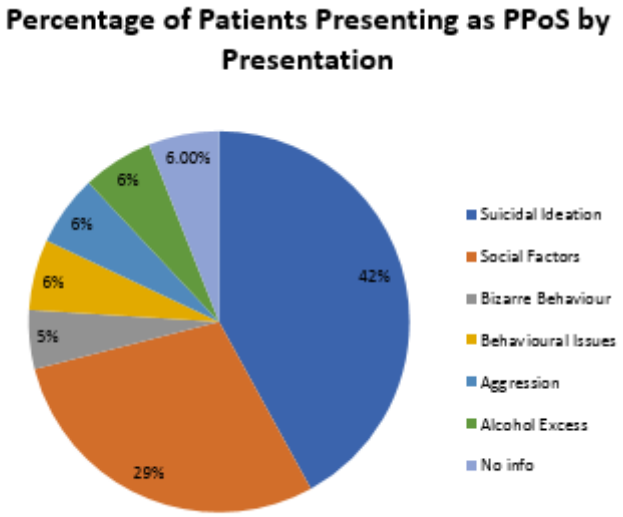
Police

Justice agencies are commonly dealing with situations where the main issues are around mental health and distress, where no offence, or only a minor offence, has been committed.

A study of "concern calls" to Division A between April 2018 until November 2018 showed that there were 1410 mental health related calls, of which 86% were closed off by police as "concern for person".

Concern calls peaked around 1900 hrs and then continued at a relatively constant level until midnight. These peak hours correlate to the peak times for detention under the Mental Health Act (Section 297) Place of Safety were 56% occurred after 2100hrs.

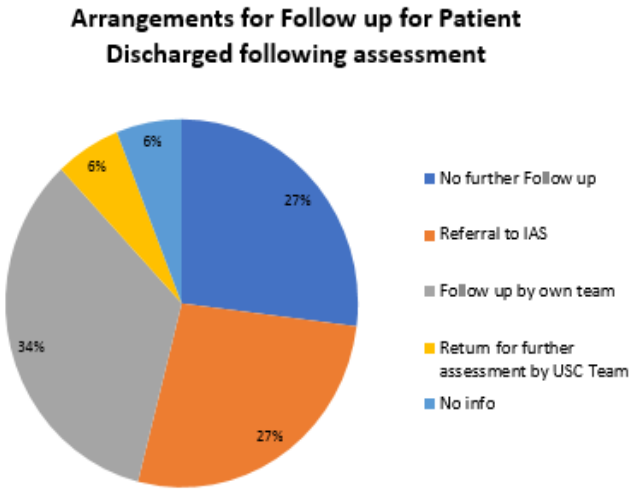
There are on average 23 Place of Safety (Sect 297) detentions locally per month (Jun-18 to Jan 19).



In 94% of cases the individuals detained under Section 297 were not admitted to RCH following assessment.

This indicates that only a very small percentage of people detained under Section 297 were assessed as requiring in patient treatment.

The follow up arrangements for those who were assessed as not requiring in patient treatment are detailed below.



The findings from the most recent Place of Safety audit are displayed in the chart above which shows that 40% of people detained under Section 297 are known to mental health services or have been assessed as requiring further psychiatric assessment.

A significant percentage of those assessed were referred for support for alcohol misuse.

A significant percentage of those assessed received no follow up after assessment and although the findings indicate that this group do not require support from specialist services, i.e. a medical intervention, it is often the case that many people will continue to express levels of distress after they have undergone specialist assessment and will continue to seek out support. This frequently takes the form of an escalating pattern of risk taking and/or confrontational behaviour.

The view of the local steering group is that this group represents a gap within the current service provision.

This service has been developed looking across all current services and looking at where potential gaps and opportunities are. A mental health pathway exists within current provision however there lacks a community model. This service looks to adapt and support anyone in distress but to triage and utilise existing services where appropriate. It will be a key part of this role to understand and make relationships with those across the system.

Expressed Need

This project responds to locally expressed need for a seamless pathway of care (Hearing the Voice and contributions of people and communities, Health and Social Care Alliance, 2019) and is in line with national integration principle to deliver services which are joined up and easy for people to access. It also supports and delivers outcomes from the key messages around reducing waiting times for support, increasing availability of non-acute treatment and

increased inter-connectivity of services within the Health and Social Care Alliance's 2019 report 'Grampian System wide Mental Health and Learning Disability Services Review'.

Informal feedback from individual's experience of services from focus group discussions, requires it to be community-based and easily accessible by public transport. There is also feedback that the service should not be 'labelled' as mental health support in order to reduce stigma.

The issue of stigma was explored by the steering group and an emerging viewpoint was that an emphasis on mental wellbeing should be clearly stated within the project title.

Within Aberdeen City there is a growing awareness of the need to deliver services for people in distress (e.g. Union St bridge). If we were to shy away from emphasising mental wellbeing within this project, it could be argued that we are perpetuating stigmatised views of mental health and wellbeing services and the people who access them.

3. Objectives

- To improve individual outcomes through early intervention, prevention and admission avoidance at times of distress to de-escalate and support individuals at times of need
- To ensure right person, right time, right place approach by enhancing current pathways and service provision at time of high demand out of hours.
- To improve individual satisfaction through timely access to appropriate services via key settings (but not exclusive to)
- To mitigate risk for low/moderate level distress which will de-medicalise and decriminalise pathways for unscheduled attendances at ED and Custody by supporting a community based and early intervention model
- Contribute to the national commitment to increase the number of mental health workers in Scotland by 800 over the next five years and specifically Aberdeen city's target of 32 workers.
- To deliver against the ACHSCP Strategic aims and objectives of prevention and early intervention.
- Reduce section 297 detentions which will release police and specialist medical capacity

4. Options Appraisal

Option 1: Status Quo – No financial impact however ACHSCP not delivering its priorities as set out in PCIP and Action 15 plans
Option 2: To test provision of Community Mental Health Nursing (CMHN) out of hours services to support those with mental health distress within custody and the emergency department (ED).
Option 3: To test external commissioning of the provision of a role providing crisis intervention and support using a compassionate conversation. Funded for 2 years with option to extend for 1+1 years.

4.1 Scoring of Options Against Objectives

Objectives	Options Scoring Against Objectives							
	1	2	3	4	5	6	7	8
To improve individual outcomes through early intervention, prevention and admission avoidance at times of distress to de-escalate and support individuals at times of need	0	2	3					
To ensure right person, right time, right place approach by enhancing current pathways and service provision at time of high demand out of hours.	0	2	3					
To improve individual satisfaction through timely access to appropriate services via key settings (but not exclusive to)	0	1	3					
To mitigate risk for low/moderate level distress which will de-medicalise and decriminalise pathways for unscheduled attendances at ED and Custody by supporting a community based and early intervention model	0	-1	3					
Contribute to the national commitment to increase the number of mental health workers in Scotland by 800 over the next five years and specifically Aberdeen city's	0	2	3					

target of 32 workers.								
To deliver against the ACHSCP Strategic aims and objectives of prevention and early intervention.	0	1	2					
Reduce section 297 detentions which will release police and specialist medical capacity	0	2	3					
Total	0	9	20					
Ranking	3	2	1					

Scoring
Fully Delivers = 3; Mostly Delivers = 2; Delivers to a Limited Extent = 1; Does not Deliver = 0; Will have a negative impact on objective = -1

4.2 Recommendation
Option 3 - To test external commissioning of the provision of a new role supporting crisis intervention and support for 2 years with option to extend for 1+1 years, is the recommended option.

5. Benefits

5.1 Citizen Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Timely access to services	Access	Manually gathered	On initial contact	Improved quality of access	December 2020	Baseline @ initial contact then follow up
Improved wellbeing	Resilience	Outcome Questionnaire	On initial contact	Improved citizen resilience	December 2020	Baseline @ initial contact then follow up
Improved quality of life	Quality of life	Outcome Questionnaire	On initial contact	Improved quality of life	December 2020	Baseline @ initial contact then follow up

5.2 Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Free up specialist capacity from 10 % Reduction in MH presentations at ED	Current number of presentations	EPR	At commencement of service	Achieve A&E waiting time HEAT target	December 2020	Baseline @ 6 &12 months
Free up police capacity from 10 % Reduction in Section 297 detentions	Current number of detentions	Annual PoS Audit	At commencement of service	Free up front line police capacity	December 2020	Annual
Establishment of an alternative recruitment and retention pathway	Increase in number of workers across mental health service	Workforce plan	At commencement of service	Decrease staff turnover rates	December 2020	Annual

5.3 Resources Benefits (financial) – indicate whether these benefits are cashable or non-cashable

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Free up specialist capacity from 10 % Reduction in MH presentations at ED – costings of registrar capacity per client	Current number of presentations	EPR	At commencement of service	Achieve A&E waiting time HEAT target	December 2020	Baseline @ 6 &12 months
Free up police capacity from 10 % Reduction in Section 297 detentions	Current number and avg time spent on detentions per person	Annual PoS Audit	At commencement of service	Free up front line police capacity	December 2020	6-monthly
Reduction in number of RCH consultations and presentations	Current number of presentations and time spent per person	Trakcare	At commencement of service	Free up front line police capacity	December 2020	6-monthly

6. Costs

6.1 Project Revenue Expenditure & Income

The total contract cost is based on Aberdeen City Health and Social Care Partnership contributing share to provide a Mental Health Wellbeing Out of Hours proposed service.

The project proposal is based on a cost split of 66% for Aberdeen City HSCP and 34% for Aberdeenshire HSCP for year 1 costs. The total contribution costs below work to the 66%/34% split for year 1 then rising to 85/15% from year 2 onwards in order to accommodate the potential budget risk based on these projections.

(From year 2 the split would be adjusted based on analysis of activity between the range of 66-85% to reflect the usage of the services as appropriate)

Total Costs:

(£)	Year 1	Year 2	*+ 1 year extension*	*+ 1 year extension*	Total
Total Service costs	£202,880	£202,349	*£206,215*	*£210,158*	£821,602
Total Payable for City Share	£133,900 (66%)	£171,997 (85%)	£175,283 (85%)	£178,634 (85%)	£659,814

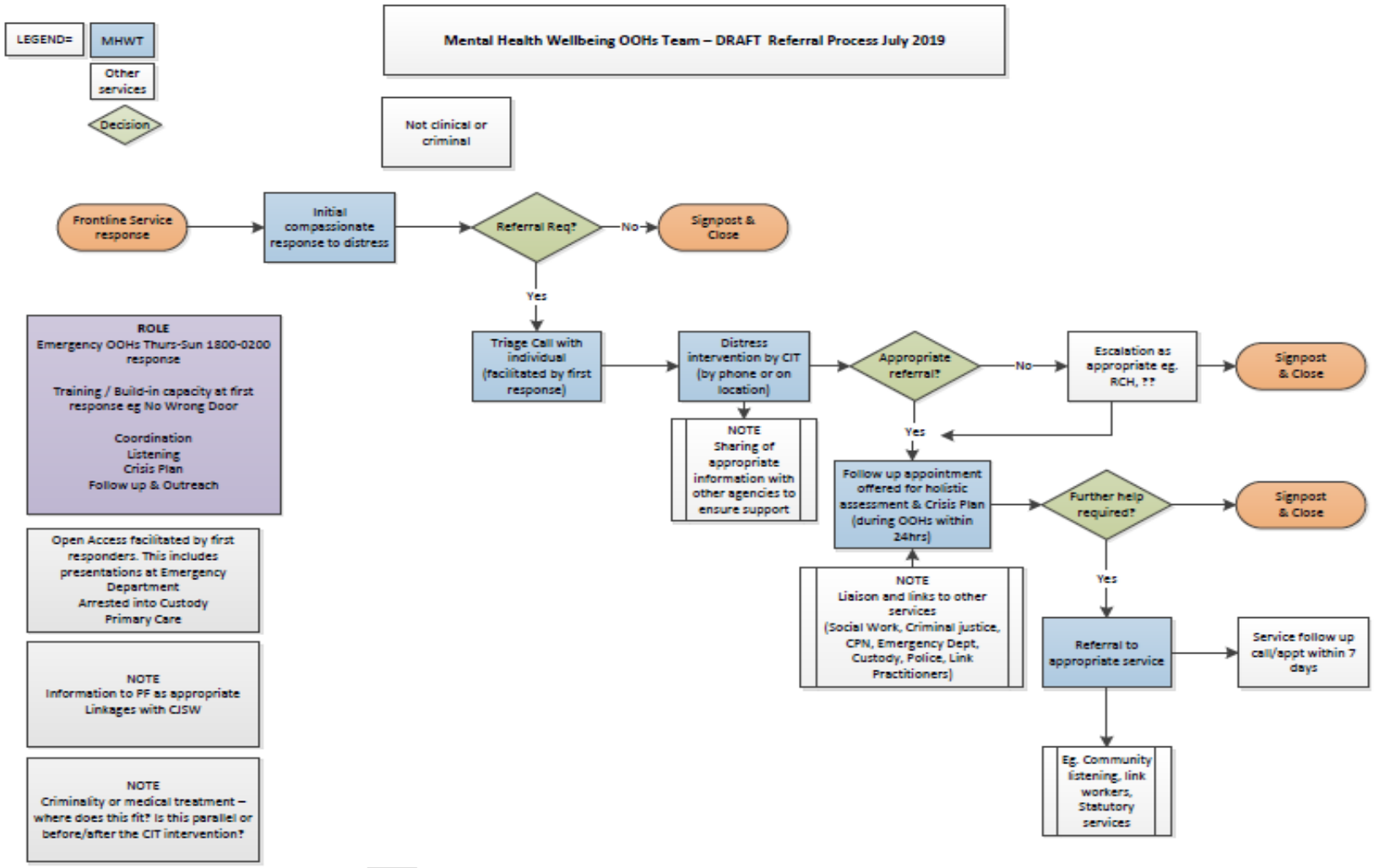
7. Key Risks	
Description	**Mitigation**
Lack of capacity in third sector to respond to local need	ACVO Third Sector Interface have been involved in the development of sit on project team to ensure that any issues are raised and to support the third sector. In addition, a meeting in July with MH providers has given them the opportunity to shape the proposal.
The appropriate escalation and access to specialist advice to mitigate clinical risk	The Unscheduled Care Team will support these posts as required. In addition, this service does not replace current pathways and access to statutory services.
Lack of joint up working and commitment from all services to support the model and 'buy-in' to the new service	Joint training and development opportunities with peers. Communication and engagement strategy will be in place to mitigate this.

8. Time
8.1 Time Constraints & Aspirations
After IJB approval, the procurement process will take around 4 months to complete. It is therefore anticipated to have a contact in place by January 2020 and service operational by early 2020. After this the project would run for 2 years with a potential extension of a further 3 years. It would be agreed that service testing and development should run through the course of the project to ensure outcomes are best met.

8.2 Key Milestones	
Description	**Target Date**
Programme Board / IJB approval	July -Sept 2019
IJB Approval	3 Sept 2019
Tendering process begins	Nov 2019
Contract in place	Jan 2020
Service operational	Apr 2020
Evaluation	Ongoing

*Note – this is a summary version of the Business Case, the full Business Case is available on request to IJB board members.

Appendix 1 – Proposed Pathway DRAFT



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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

ABERDEEN CITY COUNCIL AND NHS GRAMPIAN are hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan and existing operational arrangements pending future directions from the Board.

Related Report Number:- HSCP.201958

Approval from IJB received on:- 3rd September 2019

Description of services/functions:-

Provision of Mental Health Wellbeing Out-of-Hours Hub for Custody & A&E
Provision of a Mental Wellbeing Out-of-hours Hub within the Kittybrewster Custody Suite for period of two years (with the option to extend for 1+1 years).

Reference to the integration scheme:- Annex 1 Part 1: All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.
Annex 1 Part 2B: 20. Mental health services provided outwith a hospital.

Annex 2 Part 1: The Mental Health (Care and Treatment) (Scotland) Act 2003

Annex 2 Part 2: Mental health services

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

The provision of this hub closely with all 5 strategic aims for ACHSCP: prevention; resilience; enabling; connections; and communities. In particular it looks to have early intervention and prevention for those in distress.

Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

Timescales involved:-

Start date:- 03.09.2019
End date:- April 2023 (dependent on successful tender and recruitment)

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

NHS Grampian
ABERDEEN CITY COUNCIL

Associated Budget:-
The project proposal is based on a cost split of 66% for Aberdeen City HSCP and 34% for Aberdeenshire HSCP for year 1 costs. The total contribution costs below work to the 66%/34% split for year 1 then rising to 85/15% from year 2 onwards in order to accommodate the potential budget risk based on these projections.

(From year 2 the split would be adjusted based on analysis of activity between the range of 66-85% to reflect the usage of the services as appropriate)

Table: Costings for the Mental Health Wellbeing OOHS Hub (Custody / A&E) Project Business Case

(£)	Year 1	Year 2	*+ 1 year extension*	*+ 1 year extension*	Total
Total Service costs	£202,880	£202,349	*£206,215*	*£210,158*	£821,602*
Total Payable for City Share	£133,900 (66%)	£171,997 (85%)	£175,283 (85%)	£178,634 (85%)	£659,814

**Estimate as will be dependent on contract value. Estimates are based on Link Worker costs*

Details of funding source:- Scottish Government Action 15 Funding

Availability:- Confirmed

Prior to sending this direction, please attach a copy of the draft IJB minutes, original report and the completed consultation checklist.

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	Alcohol Drug Partnership Update
Report Number	HSCP19051
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Simon Rayner
Consultation Checklist Completed	yes
Directions Required	*yes*
Appendices	Appendix 1 Spending Proposal Appendix 2 Directions to ACC and NHSG

1. Purpose of the Report

1.1. The Scottish Government has provided Alcohol and Drug Partnerships (ADPs) across Scotland additional recurring funding. For Aberdeen City this equates to £666,404 per year. The funding is allocated to locally deliver the national strategy: Rights, Respect, Recovery.

1.2. The IJB is accountable for the financial governance of this investment. This paper is presented to the IJB to allow ratification of the ADP proposal and to direct NHS Grampian and Aberdeen City Council accordingly. This report sets out the detail of the intended investment as agreed by the ADP on the 31st May 2019.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Approve the expenditure as set out in paragraph 4.3; and

b) Make the Directions as set out in Appendix 2 relating to the five workstreams set out in Appendix 1 and instructs the Chief Officer to issue the Directions to the Aberdeen City Council and NHS Grampian.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1 The Scottish Government allocated £666,404 on a recurring basis from September 2018. In the financial year 2018/19 £666,000 of funding was not spent and was carried forward into financial year 2019/20, as the funding announcement was delayed pending the publication of a national strategy. This makes the total amount available for investment in 2019/20 as £1,332,404. This report details investment of the full £1,332,404 with investments proposed on a mixture of recurring and fixed term basis. The detail of the intended investment was agreed by the ADP on the 31st May 2019.

3.2 The key challenges in relation to drugs and alcohol for Aberdeen City are:

- High rates of drug related death – 52 in 2018 – predominantly in areas of higher deprivation,
- High rates of alcohol related death – 51 in 2018 – predominantly in areas of higher deprivation,
- High numbers of alcohol related illness and hospital admission,
- Complex poly-drug use,
- Ageing demographic of drug users: A high proportion of this population have multiple underlying health conditions and have a physiological health age which is comparable to those who are 15 years older in the general population (Scottish Government / Scottish Drugs Forum 2017),
- The government have indicated that, across Scotland, we need to increase capacity to ensure the most vulnerable have “low threshold” access to treatment and increase the retention in treatment services and in particular Opiate Substitution Therapy (OST).

3.3 The development of the investment detail involved discussion with:

- Public, localities, communities of interest and service users,
- Professionals,
- Community Planning Partnership; specifically Community Justice Board, Integrated Children’s Services Board, Resilient, Included and Supported Group as well as Alcohol & Drugs Partnership,

- Public Health and Managed Clinical Network for Sexual Health and Blood Borne Viruses,
- Aberdeen Health and Social Care Partnership staff.

3.4 The ADP membership has representation from the following agencies

- Police Scotland,
- Scottish Prison Service,
- Aberdeen City Council,
- NHS Grampian Public Health,
- Aberdeen Health and Social Care Partnership,
- Scottish Fire and Rescue Service,
- ACVO,
- Civic Forum,
- Aberdeen In Recovery (people with lived experience of addictions),
- Drug, Alcohol and Blood Borne Virus Forum.

3.5 The ADP is an Outcome Improvement Group of Community Planning Aberdeen. The ADP has a stretch aim of *"Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026"*, as well as improvement charters to:

- *Increase the % of Care experienced children and young people receiving educational and support input on alcohol/ drugs issues by 2021,*
- *100% of schools have a progressive, cohesive and relevant substance misuse curriculum by 2021,*
- *Reduce the number of births affected by drugs by 0.6 %, by 2022,*
- *Increase % of the population who feel informed about using alcohol responsibly by 2021,*
- *Increase by 10% the percentage of adults in Aberdeen City who are non drinkers or drink alcohol in a low risk way by 2021,*
- *Increase the number of Number of alcohol licensed premises awarded Best Bar None status by 2021,*
- *Increase number of alcohol brief interventions delivered by Primary Care providers and other professionals by 100% by 2021,*

- *Increase the uptake of alcohol treatment by improving access to alcohol services and ensuring they are local, integrated and targets areas of greatest need by 10% year on year by 2021,*
- *Reduce the incidence of fatal drug overdose through innovative developments and by increasing the distribution of naloxone by 10% year on year by 2021,*
- *Increase opportunities for individuals who have been at risk of Blood Borne Viruses, being tested and accessing treatment by 2021,*
- *Increase uptake of drug treatment and specifically within Locality Areas by 10% each year by 2021,*
- *Increase number of people undertaking recovery from drug and alcohol issues who are being supported to maintain drug / alcohol free lives in their community by 2021,*
- *Increase the uptake and retention of people in the Justice System with drug and alcohol related problems in specialist substance use services by 100% by 2021.*

3.6 The five business cases were presented to the AHSCP Executive Programme Board of the 14th August 2019. The business cases set out standard details of the business need, objectives, scope, risks, assumptions, dependencies, constraints etc. All five business cases were agreed and will help to deliver the outcomes from the LOIP and the IJB Strategic Plan.

3.7 The ability to recruit clinical staff is seen as a potential risk to delivery. This has been partly offset through investing in an improvement programme to encourage recruitment into the sector. Employment of clinical staff is the preferred option, however, if this is unsuccessful we will revisit other options. The investment will support an overall redesign of services towards longer term sustainable models of delivery.

3.8 In summary this investment supports a range of action across the Alcohol and Drugs Partnership, the Health and Social Care Partnership and Community Planning Partnership to work together to tackle drug and alcohol related issues. It supports whole system approaches and seeks to include and involve localities, the public, service users and those with lived experience of recovery.

3.9 The investment is spread across a range of strategic interventions with allocations approximately distributed as:

- *46% prevention and early intervention,*
- *43% treatment and tertiary prevention,*
- *4% invested in recovery,*
- *4% invested in improving intelligence,*
- *3% not allocated to be carried forward.*

3.10 The values invested don't necessarily represent the "priority level" of an activity –they also reflect the cost of "doing" something. Within the ADP delivery plan and the Community Planning Aberdeen LOIP there are a significant number of improvement projects that intend to use existing resources differently and more effectively, therefore the investment does not represent the totality of activity that the ADP aspires to.

4 Implications for IJB

4.1 Equalities

This investment will have a *positive* impact on communities and service users through additional service capacity, improved access to support and improved service quality.

This investment will have a *positive* impact on staff in relation to investment in training, professional development and increased staff numbers.

This investment will have *no negative* impact on employees, service users or other people who share characteristics protected by The Equality Act 2010

4.2 Fairer Scotland Duty

This investment will have a *positive* impact on reducing *the inequalities of outcome which result from socio-economic disadvantage.*

4.3 Financial – contained in Appendix 2 and summarised below:

INTEGRATION JOINT BOARD

	ACC	ACC	NHS	NHS	
	Recurring (£)	Non-Recurring (£)	Recurring (£)	Non-Recurring (£)	Total (£)
Workstream 1 Allocation	100,000	45,000	0	0	145,000
Workstream 2 Allocation	29,895	43,177	59,256	220,000	352,328
Workstream 3 Allocation	44,000	0	348,087	10,000	402,087
Workstream 4 Allocation	0	0	40,000	0	40,000
Workstream 5 Allocation	0	0	25,898	50,000	75,898
Workstream Localities	0	300,000	0	17,091	317,091
TOTAL	173,895	388,177	473,241	297,091	1,332,404

4.4 Workforce – contained in Appendix 2.

4.5 Legal - There are no direct legal implications arising from this report.

4.6 Other - There are no other anticipated implications as a result of this report.

5 Links to ACHSCP Strategic Plan

5.1 The Scottish Government expect to see alcohol and drugs as an identifiable section within the AHSCP Strategic Plan. This plan, the ADP Delivery Plan and priorities within the Community Planning Partnership should all be corporate and work is being undertaken to ensure this.

6 Management of Risk

6.1 Identified risks(s)

Recruitment of clinical staff is a potential risk to delivery.

6.2 Link to risks on strategic or operational risk register:

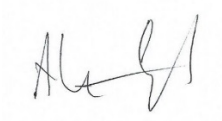
Adult drug treatment services are currently graded “High Risk” on the risk register due to ongoing vacancies; service capacity and the ongoing negative impact on waiting times and patient safety.

6.3 How might the content of this report impact or mitigate these risks:

INTEGRATION JOINT BOARD

This investment will bring additional service capacity, opportunity for redesign and partnership working which will help mitigate risks.

A recruitment programme led by quality improvement processes is being used to encourage recruitment of new staff.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

INTEGRATION JOINT BOARD

Appendix 1

Summary of investment details

Workstream 1: Whole Family Approach

1a *We will fund, in line with ADP specification, a Guidance Teacher part time for 12 months to develop resources and develop staff at the value of up to £45,000*

2 Work Stream Reduce Harm, Morbidity and Mortality

This Workstream encompasses primary, secondary and tertiary prevention in relation to reducing harm, morbidity and mortality. We will take whole-population approaches to reducing alcohol consumption, with the aim of preventing harm. Where people are using drugs and alcohol we will ensure there are appropriate supports to allow people to reduce risks and harm and improve access to help for the most at risk. We will aim to reach out to people who are vulnerable either by location or circumstances and seek to work in partnership with communities and colleagues across housing, health, social care and justice to ensure a "whole system" response.

We will:

2a Procure from the 3rd sector, in line with ADP specification, 2 x Assertive Outreach Workers for a fixed period of 2 years at a value of up to £135,000 to work with homelessness, rapid housing, overdose prevention

2b Fund in conjunction with Violence Against Women Funding, in line with ADP specification, a Housing / Domestic Abuse Worker at the value of up to £30,000 per year to improve tenancy retention, support women and pathways

2c Fund, line with ADP specification, a Band 7 RGN Advanced Nurse Practitioner Nurse up to the value of £59,256 to improve general health and respond to increasing presentations of poor general health from older drug users across the sector

2d Fund, for a fixed period of 12 months, in line with ADP specification a Locality Based Development Worker at the value of up to £43,177.to help support and engage localities to develop improvements and delivery ADP priorities and to support our ambition for our strategy to be rooted in community action

2e *Fund, in line with ADP specification, 1x Custody Link Worker up to the value of £80,000 over a two year fixed period to support continuity of treatment and care between community and justice (previously agreed by the IJB).*

3 Work Stream 3 Service Quality and Outcome Improvement

This Workstream encompasses primary, secondary and tertiary prevention in relation to reducing harm, morbidity and mortality, and whole-population approaches to reducing alcohol consumption with the aim of preventing harm. Where people are using drugs and alcohol in risky ways, we will ensure there are appropriate supports to allow people to reduce harm and services to help facilitate this. We need to ensure that those at greatest risk of harm from drugs and alcohol have access to appropriate support to reduce risk as easily as possible. We will ensure our services are able to demonstrate a high standard of delivery and reportable quality-assurance outcomes in line with national and local expectations. We will involve service users in our quality-assurance processes. We will ensure that our staff working in specialist addiction services are appropriately supported and valued in our quality processes to ensure best possible care, recruitment and retention. In line with the National Quality Principles service users should be supported by workers who have the right attitudes, values, training and supervision throughout the recovery journey. We will support specialist addiction services to reduce harm and support the most at risk to seek help. We will develop innovative ways to engage those most at risk and seek to improve quality of life. We will seek to ensure that there are opportunities for those at risk to reduce harm through the provision of health improvement work to reduce harm and improve health and wellbeing outcomes. We will build the capacity of our specialist drug services to improve access whilst maintaining waiting times standards. We will seek to increase retention in drug treatment.

We will:

3a *fund in line with ADP specification increase scale and pace of change of the Alcohol Hub model, specifically:*

i. *a Social Worker to work within the AHSCP Integrated Alcohol Service up to the value of up to £49,000 per year Extension of alcohol hubs by two this will increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs.*

ii *a Band 6 nurse to work in the Integrated Alcohol Service up to the value of £50,276 per year*

iii *12 GP sessions per year and 12 Consultant GI Sessions per year*

3b *continue to fund the existing Alcohol Hubs at a value of £12,000 for the provision of 12 GP sessions and 12 Consultant GI sessions per year*

3c *fund, line with ADP specification, four Band 6 nurses to work in the Integrated Drug Service up to the value of £50,276 per year each to increase capacity and to facilitate improved service user retention, increase innovation and improve outcomes to meet national quality standards*

3d *fund, line with ADP specification, a Band 8a nurse to work across the Integrated Drug Service and the Integrated Alcohol Service up to the value of £68,983 per year to lead quality improvements, lead on non medical prescribing, lead on trauma informed care, outreach for complex cases and overdose incidence*

3e *fund, in line with ADP specification, the development of a new way of working with Primary Care Vision / EMIS system at a value of £10,000 per year that will improve our ability to performance manage BBV testing, Medicine Reviews, Contraception Reviews etc*

3f *fund, in line with ADP specification, Staff / workforce development / recruitment and retention programme at a value of £10,000 to help mitigate against staff recruitment risks*

4 Supporting Recovery

An individual's recovery from a drug or alcohol-related problem is personal to them. Different people will achieve recovery in different ways and it is our role to ensure that there are appropriate supportive opportunities to allow people to sustain their recovery in their community. Increasing the visibility of recovery gives strength and hope to others who are on their own journey. Increasing the visibility of recovery helps reduce stigma and can put a human face to the complex issues underlying drug and alcohol use. Ensuring that there are a range of options for people to engage in recovery helps give resilience and reduce isolation. We will seek to remove barriers to recovery and support housing, employability and education opportunities.

We will

4a *grant fund, in line with ADP specification, Aberdeen In Recovery (Scottish Charity number SC049125) up to the value of £40,000 per year Grant Fund* ***Aberdeen In Recovery*** *to provide peer led recovery support group and undertake*

a range of groups, activities. AiR recently became established as a registered charity with OSCR.

5 Intelligence Led

Knowledge and understanding in relation to the underlying causes of drug and alcohol problems are increasing all the time and this understanding helps us develop effective evidenced-based strategies for reducing the negative impact on our society. We want to ensure that people have access to knowledge and information about drugs and alcohol to encourage personal choice and self-care. We want to hear from people and communities affected by drugs and alcohol and we want to be able to inform them of our work and how they can help. To do this we need to be able to measure our progress and report our performance against our aspirations.

We will

5a *fund data management capacity at a value of £ £25,898 per year reduce demand on practitioners and prepare for Scottish Government DAISY system coming on stream in January 2020. Longer term we will develop a digital strategy for our addiction services*

5b *fund in line with ADP specification, a development programme at a value of £50,000 to lead a cohort of senior officers and the ADP through process of "discovery" examining world class evidence to formulate innovations and improvements at a strategic level for the City*

Locality Partnerships

Engaging local communities and ensuring that our strategies meet the needs of the population is a key component of effective delivery. In preparation for the implementation of Community Planning and AHSCP localities we will allocate resource to each locality. This resource to allow communities to help deliver the ADP framework and support local grass roots activity. Help shape the future ADP delivery plan through improved intelligence and co-production.

We will:

5c *make available, on a non recurring basis, £300,000 for the three City localities, North, Central and South to develop community based responses to drug and alcohol issues and to help local communities deliver the ADP Objectives*

INTEGRATION JOINT BOARD

Appendix 2

INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

ABERDEEN CITY COUNCIL AND NHS GRAMPIAN are hereby directed to deliver for the Board, the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the Board's Strategic Plan, Appendix A to this report and existing operational arrangements pending future directions from the Board.

Related Report Number: - HSCP201955

Approval from IJB received on: - 3rd September 2019

Description of services/functions: -

To support the delivery of the Alcohol and Drug Partnership strategic delivery as detailed in the five workstreams business cases as attached to this Direction, specifically:

Aberdeen City Council:

1a To provide leadership, develop resources and implement project charter, ensuring that 100% of schools have % of schools with a progressive, cohesive and relevant substance misuse curriculum

2a To provide, for a fixed period of 2 years, support to people who are homeless or rapidly re-housed and people who are at risk of overdose to specifically help reduce the rate of drug related deaths in this target group

2b To provide a recurring Housing / Domestic Abuse development service in-conjunction with the Violence Against Women partnership to improve pathways, joint working, retention of tenancy, anti-social behaviour, rent arrears and to specifically support women into treatment services and specifically women affected by substance use and domestic abuse

2d To provide developmental capacity for a fixed period of 12 months to help support and engage localities to develop improvements and delivery ADP priorities and to support our ambition for our strategy to be rooted in community action in line with Local Outcome Improvement Plan

3a To provide a recurring Social Work service to facilitate the extension of alcohol hubs to increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs

NHS Grampian

2c To provide a recurring Advanced Nurse service to improve general health and respond to increasing presentations of poor general health from older drug users across the sector from a number of key service locations across the city

3a Provide a recurring specialist alcohol mental health nursing service to facilitate the extension of alcohol hubs to increase capacity and establish alcohol services in areas of greatest need with a plan to link longer term to Community Care and Treatment Hubs.

3b To continue to provide alcohol hubs in Kincorth and in Woodside

3c To provide recurring additional specialist nursing service capacity within the Integrated Drug Service increase capacity and to facilitate improved service user retention, increase innovation and improve outcomes to meet national quality standards

3d To provide recurring a senior mental health nurse practitioner service to lead quality improvements, lead on non medical prescribing, lead on trauma informed care, provide outreach for complex cases and overdose incidence

INTEGRATION JOINT BOARD

3e To provide new way of working with Primary Care Vision system that will improve the ability of clinicians to performance manage BBV testing, Medicine Reviews, Contraception Reviews etc

3f To provide a staff / workforce development / recruitment and retention programme to help mitigate against staff recruitment risks

4a To grant Fund **Aberdeen In Recovery** – (AiR) is a peer led recovery support group to under a range of supports, groups, activities.

5a To provide recurring data management capacity to reduce demand on practitioners and prepare for Scottish Government DAISY system coming on stream in January 2020.

5b To provide over a fixed period a development programme to lead a cohort of senior officers and the ADP through process of "discovery" examining world class evidence to formulate innovations and improvements at a strategic level for the City

5c Provide local communities with resources over a fixed period to ensure that the ADP Strategy meets the needs of the population allow communities to help deliver the ADP framework and support local grass roots activity to help shape the future ADP delivery plan through improved intelligence and co-production.

All investments will be supported by a Service Level Agreement or Service Specification provided and monitored through the Alcohol and Drug Partnership.

- **Reference to the integration scheme: -**

Annex 1 Part 2:

6. Services provided in a hospital in relation to an addiction or dependence on any substance.
9. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

Annex 2 Part 1:

• Drug and alcohol services

Link to strategic priorities (with reference to strategic plan and commissioning plan):-

- Reduction in number of drug-related deaths:
- Reduction in number of drug-related hospital admissions

INTEGRATION JOINT BOARD

- Reduction in number of alcohol-related deaths
- Reduction in number of alcohol-related hospital admissions

Timescales involved:-

Start date: - 3 September 2019

End date: - Ongoing

Associated Budget:-

	ACC Recurring (£)	ACC Non-Recurring (£)	NHS Recurring (£)	NHS Non-Recurring (£)	Total (£)
Workstream 1 Allocation	100,000	45,000	0	0	145,000
Workstream 2 Allocation	29,895	43,177	59,256	220,000	352,328
Workstream 3 Allocation	44,000	0	348,087	10,000	402,087
Workstream 4 Allocation	0	0	40,000	0	40,000
Workstream 5 Allocation	0	0	25,898	50,000	75,898
Workstream Localities	0	300,000	0	17,091	317,091
TOTAL	173,895	388,177	473,241	297,091	1,332,404

Details of funding source: - The Scottish Government allocation of £666,404 recurring funding to Alcohol and Drug Partnerships.

Availability: - Confirmed

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	3 September 2019
Report Title	IJB Meeting Dates 2020-21
Report Number	HSCP/19/048
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	*Name:* Derek Jamieson *Job Title: Committee Services Officer* *Email Address:* derjamieson@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	*No*
Appendices	None

1. Purpose of the Report

1.1. To propose Integration Joint Board (IJB) meeting and developmental workshop session schedules for 2020-21.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Review and approve the IJB, Audit & Performance Systems Committee (APS) and Clinical Care Governance Committee (CCG) schedule for 2020-21;

b) Note that the stand-alone developmental workshop schedule for 2020-21 will be reported later; and

c) Agree for the meeting schedule to be published on the Partnership's website.

3. Summary of Key Information

3.1. As per Standing Orders, Article 9(5), the Board is required to approve an annual meeting schedule prior to the new financial year.

3.2. At its meeting on 27 March 2018, the Board agreed to annually review its meeting arrangements when the next annual schedule of meetings would be presented to the Board and Members are invited to do so at today's meeting.

3.3. It is proposed that the IJB continue to meet on Tuesday mornings, in the Health Village on a 6-8-week cycle. No meetings have been scheduled during public holidays or the Council's summer recess period. No meetings currently clash with Aberdeen City Council or NHS Grampian Board meetings.

3.4. As per the decision of the Board on 27 March 2018, all meetings of the IJB are scheduled to run between 10:00am and 3:30pm and may incorporate developmental workshop sessions following the business meeting.

3.5. A proposed meeting has been scheduled for 23 June 2020 which would allow the Board to approve the Partnership's Annual Report within four months of Year-End as required by the Scottish Government.

3.6. As per the IJB Budget Protocol agreed by the Board at its meeting on 7 March 2017, a dedicated budget meeting has been scheduled for 11 February 2020 to allow the Board to agree a budget before Aberdeen City Council and the NHS Grampian Board set their annual budgets. A provisional budget meeting has been included within the schedule in the event that the Board has to take further budgetary decisions following the annual budget meetings of its two partners.

3.7. The Board has already approved the following 2020, 2021 dates, all within the Health Village :-

INTEGRATION JOINT BOARD

10:00am, 11 February 2020 (Budget),
10:00am, 10 March 2020, (Provisional 2nd Budget Meeting) and
10:00am, 24 March 2020.

3.8. The Board is requested to review and approve the following meeting schedule:-

10:00am, 23 June 2020 – Health Village
10:00am, 8 September 2020 – Health Village
10:00am, 1 December 2020 – Health Village
10:00am, 9 February 2021 – Health Village

3.9. To assist the overall business of the Board, the following dates have been proposed for its Committees.

Audit and Performance Systems Committee

10:00am, 28 April 2020 – Health Village (Unaudited Accounts)
10:00am, 2 June 2020 – Health Village (Audited Accounts)
10:00am, 25 August 2020 – Health Village
10:00am, 3 November 2020 – Health Village
10:00am, 26 January 2021 – Health Village

Clinical and Care Governance Committee

10:00am, 5 May 2020 – Health Village
10:00am, 28 July 2020 – Health Village
10:00am, 20 October 2020 – Health Village
10:00am, 12 January 2021 – Health Village

3.10. Approval of the proposed timelines would allow a workflow timeline and pre-agenda meetings as follows.

INTEGRATION JOINT BOARD

20/21	Draft Reports Consultation	Draft Reports Pre-Agenda	Pre-Agenda 9am - 10:30 (Wed)	Final Reports Deadline	Committee Date	Late at Draft	Late at Final
CCG	31.03.20	14.04.20	22.04.20	28.04.20	05.05.20		
	23.06.20	07.07.20	15.07.20	21.07.20	28.07.20		
	15.09.20	29.09.20	07.10.20	13.10.20	20.10.20		
	01.12.20	15.12.20	23.12.20	05.01.21	12.01.21		
APS	24.03.20	07.04.20	15.04.20	21.04.20	28.04.20		
	28.04.20	12.05.20	20.05.20	26.05.20	02.06.20		
	21.07.20	04.08.20	12.08.20	18.08.20	25.08.20		
	22.09.20	06.10.20	14.10.20	27.10.20	03.11.20		
	15.12.20	05.01.21	13.01.21	19.01.21	26.01.21		
IJB	05.02.20	19.02.20	26.02.20	03.03.20	10.03.20		
	19.05.20	02.06.20	10.06.20	16.06.20	23.06.20		
	04.08.20	18.08.20	26.08.20	01.09.20	08.09.20		
	27.10.20	10.11.20	18.11.20	24.11.20	01.12.20		
	13.01.21	20.01.21	27.01.21	02.02.21	09.02.21		

3.10. As per the decision of the Board on 28 August 2018, four stand-alone developmental workshop sessions, the content identified by the Board and its Committees, will be scheduled to facilitate the delivery of external governance support.

INTEGRATION JOINT BOARD

4. Implications for IJB

4.1. **Equalities –** It is proposed that IJB meetings continue to be held in the Health Village which is a modern building and more accessible to equalities groups.

4.2. **Fairer Scotland Duty –** None directly arising from this report.

4.3. **Financial-** None directly arising from this report.

4.4. **Workforce**- It is anticipated that a meeting schedule which is publicly available on the Partnership's website would be beneficial for Aberdeen City Council, NHS Grampian and Partnership workforces. By scheduling IJB meeting dates up to March 2020, Board members, officers, auditors and stakeholders would be able to plan ahead and effectively prepare for Board meetings.

4.5. **Legal-** Approval of a meeting schedule would help to ensure that the IJB was able to carry out its statutory duties and functions.

5. Links to ACHSCP Strategic Plan

5.1. The Strategic Plan sets out the aims, commitments and priorities of the Partnership, in alignment with Community Planning Aberdeen's Local Outcome Improvement Plan (LOIP), NHS Grampian's Clinical Strategy and Aberdeen City Council's Local Housing Strategy. Aberdeen City Health & Social Care Partnership (ACHSCP) and its governance body, the Integration Joint Board, have now been operating for over three years. During this time, real progress has been made to integrate the health and social care services delegated from our partners, Aberdeen City Council and NHS Grampian. The Integration Scheme requires adoption of good governance which has proven essential to delivery of the partnerships services and developments.

6. Management of Risk

6.1 **Identified risk(s):** The Board would be unable to take timely and informed decisions without an agreed meeting schedule; this would undermine the effectiveness of the Board's governance arrangements.

INTEGRATION JOINT BOARD

6.2 **Link to risk number on strategic or operational risk register:** Strategic Risk Register (3) Failure of the IJB to function, make decisions in a timely manner etc

6.3 **How might the content of this report impact or mitigate the known risks:** By agreeing a meeting schedule the Partnership would be able to ensure reports captured the views of key stakeholders during the consultation process. The Board would then be in a position to take informed and timely decisions to support the functions and strategic objectives of the Partnership.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	03.09.2019
Report Title	IJB Standards Officer
Report Number	HSCP19047
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Martin Allan Job Title: Business Manager Email Address: martin.allan3@nhs.net
Consultation Checklist Completed	*Yes*
Appendices	None

1. Purpose of the Report

1.1. To inform the IJB of the requirement to nominate a replacement Standards Officer to the Standards Commission, following the retirement of the previous incumbent.

2. Recommendations

2.1. It is recommended that the IJB:

a) Nominate the Interim Democracy Manager as a replacement Standards Officer to the Standards Commission, as detailed in the report.

3. Summary of Key Information

IJB Standards Officer

3.1. Each body (the IJB is one) which comes under the Model Code of Conduct for Devolved Public Bodies is required to appoint a Standards Officer.

3.2. The Standards Officer's duties include providing training on the Model Code and maintaining the Register of Members' Interests.

3.3. The IJB on the 26th of April, 2016 nominated the Interim Democratic Manager of Aberdeen City Council to the Standards Commission. The nomination was subsequently approved.

3.4. The Interim Democracy Manager is retiring as of 31/8/19 and the Chief Officer of Governance, Aberdeen City Council has appointed a replacement Interim Democracy Manager.

3.5. The IJB are being asked to consider nominating a new Standards Officer.

3.6. In the interim between nomination and approval by the Standards Commission any queries in relation to the Model Code can be directed to the Chief Officer of Governance.

Implications for IJB

3.7. **Equalities –** while there are no direct implications arising directly as a result of this report, equalities implications will be taken into account by the Standards Officer.

3.8. **Fairer Scotland Duty –** while there are no direct implications arising directly as a result of this report, the Fairer Scotland duty will be taken into account, where appropriate, by the Standards Officer.

3.9. **Financial** – while there are no direct implications arising directly as a result of this report, financial implications will be taken into account by the Standards Officer.

3.10. **Workforce -** there are no direct implications arising directly as a result of this report.

3.11. **Legal -** this report ensures compliance with the Model Code of Conduct for Devolved Public Bodies by seeking a nominated Standards Officer.

3.12. **Other -** there are no direct implications arising directly as a result of this report.

4. Links to ACHSCP Strategic Plan

INTEGRATION JOINT BOARD

4.1. The Strategic Plan sets out the aims, commitments and priorities of the Partnership, in alignment with Community Planning Aberdeen's Local Outcome Improvement Plan, NHS Grampian's Clinical Strategy and Aberdeen City Council's Local Housing Strategy. Aberdeen City Health & Social Care Partnership and its governance body, the Integration Joint Board, have now been operating for over three years – and during this time, real progress has been made to integrate the health and social care services delegated from our partners, Aberdeen City Council and NHS Grampian. Part of the Governance around the IJB is the role that the Standards officer undertakes, as detailed in the report.

5. Management of Risk

5.1. **Identified risks(s):** Reputational Damage.

5.2. **Link to risks on strategic or operational risk register:** The Standards Officer role will help to mitigate all of the risks on the IJB's Strategic Risk Register, however the main risk that the Officer's role will help mitigate is "There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care"

5.3. **How might the content of this report impact or mitigate these risks:** Ensuring that all Members of the IJB are properly trained on the Model Code of Conduct, including the registration of interests will help mitigate the risk of reputational damage.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

INTEGRATION JOINT BOARD

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	3rd September 2019
Report Title	Aberdeen City Health & Social Care Partnership Winter Plan 2019/20
Report Number	HSCP19045
Lead Officer	Sandra Ross (Chief Officer)
Report Author Details	Kenneth O'Brien Service Manager kobrien@aberdeencity.gov.uk 01224 556 201
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	One – Partnership Draft Winter Plan

1. Purpose of the Report

1.1. The Aberdeen City Health and Social Care Partnership is required to develop a "Winter Plan" each year to reflect arrangements to support activity over the winter period. The draft Winter Plan before the IJB for period 2019/20 is contained in Appendix One to this report.

1.2. This report to the IJB:

- Gives a brief description of the context and process behind the creation of the current Winter Plan for the Partnership;
- Documents the testing arrangements put in place regarding the 2019/20 Winter Plan;
- Sets out the monitoring arrangements for the Winter Plan.

INTEGRATION JOINT BOARD

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Review and approve the 2019/20 Winter Plan for the Aberdeen City H&SCP (Appendix One) and instruct the Chief Officer to send the Plan to NHS Grampian for inclusion in the Grampian wide Winter Plan.

b) Endorse the review arrangements for the Aberdeen City H&SCP Winter Plan for over the 2019/20 winter period (as set out in section 3).

c) Authorises the Chief Officer to commit any money received from the Scottish Government for the winter plan 2019/20, should such monies be received.

3. Summary of Key Information

Context & Process

3.1. The winter period can be challenging for health and social care services. Demand for services can be very high and the ability and capacity of teams and resources to respond is often tested. To address such challenges the Scottish Government has directed Health Boards to undertake robust winter planning that is shared and coordinated with partners in Health and Social Care Partnerships.

3.2. As part of its contribution towards this process, the Aberdeen City H&SCP is required to create its own Partnership specific Winter Plan. The plan needs to set out how the Partnership is prepared for this winter to minimise any potential disruption to its services, patients/clients and informal carers. The plan also must ensure safe and effective care for patients/clients and that there are effective levels of capacity and funding in place to support service delivery and expected activity levels.

3.3. Resultantly, a draft Winter Plan has been created (see appendix one) which documents various actions and activities to ensure the continuity of the Partnership's own services and its links with the wider health and social care system.

INTEGRATION JOINT BOARD

3.4. The entirety of the City Partnership's Senior Leadership Team (reflecting all services within the scope of the Partnership), has contributed to and approved the current draft of the Winter Plan before the IJB. This was through both a 'debrief and learning' session looking at the past winter (2018/19) and subsequent 'workshop' style drafting session for the current Winter Plan. These sessions also included key operational staff who contributed to both the debrief and drafting workshop sessions.

3.5. Although the winter plan is for the Health and Social Care Partnership and its services, there has been wider consultation, with Bon Accord Care being briefed on developments, alongside bodies such as Scottish Care participating in the workshop process.

3.6. In addition, a draft version of the current Winter Plan was also provided to NHS Grampian, as a body, for their consideration on 30th July 2019.

3.7. The City Partnership's Executive Programme Board reviewed the winter plan and operationally approved it on 14th August 2019.

3.8. The Audit and Performance Systems Committee of the Aberdeen City IJB received a report on the 20th August 2019 outlining key findings/learning from the debriefs from winter 2018/19. This covered national, Grampian and Aberdeen City specific learning.

3.9. If approved by the IJB, the City H&SCP Winter Plan will be sent onwards to NHS Grampian, in time for them to submit their full Grampian wide document to Scottish Government by their deadline of 31st October 2019.

Winter Plan Testing

3.10. A City Partnership specific test was held on 13th August 2019. This independently facilitated exercise focussed purely on the City Partnership's Winter Plan, using a realistic but fictitious test scenario involving increased demand during a period of severe/inclement weather. Any learning from this test has either been incorporated into the current draft of the Winter

Plan before the IJB, or passed on to the relevant operational teams to action.

3.11. A test of the full Grampian wide Winter Plan – based on drafts of Winter Plans from the Acute sector and City, Shire and Moray Partnerships will be conducted in September/October 2019. The City Partnership will participate fully in this test as well and will make any necessary adjustments as result of learning that arises from the Grampian wide testing.

Ongoing Monitoring and Review

3.12. It is brought to the IJB's attention that the Aberdeen City H&SCP Winter Plan will be a standing item at the City Partnership's monthly Leadership Team meeting. This will ensure that the Winter Plan is being implemented and is appropriately managing demand pressures as winter 2019/20 progresses.

3.13. Specific elements of the Winter Plan (such as delayed discharges, patient flow, vacancy/sickness reporting etc), will be monitored more frequently – as documented in the detail of the plan itself.

4. Implications for IJB

4.1. Equalities

The patients/clients of the services of the City H&SCP are disproportionately older adults and adults with chronic illness and/or long-term disabilities. Whilst 'age' and 'disability' are protected equality characteristics, it is not anticipated that there will be anything other than a positive impact for both groups via improved preparedness over the winter period.

4.2. Fairer Scotland Duty

There are not anticipated to be any Fairer Scotland Duty implications relating to this report.

4.3. Financial

There are no unfunded financial implications within this paper and appendix. Any Winter Planning arrangements are either already funded via previously agreed budgets or have specific funding and governance already attached to them (e.g. 6 Essential Actions monies, delayed discharge funds etc).

It should be noted that the Scottish Government has, in previous years, provided dedicated funding to health boards and their aligned health and social care partnerships to support winter preparedness. There has been no confirmation, yet, as to whether such funds will be provided for winter 2019/20. If such funds were to be made available, the partnership would review its winter planning activities accordingly.

4.4. Workforce

There only potential workforce implication relating to this paper and its appendix is the intention for the Partnership to review its needs regarding public holiday working over the winter period. Any proposed changes that arise from such a review would follow normal protocols and HR guidance.

4.5. Legal

There are no legal implications related to this paper and its appendix.

4.6. Other

No other implications.

5. Links to ACHSCP Strategic Plan

5.1. The Partnership's Strategic Plan set a very clear intention to shift the balance of care to community-based models. The Winter Plan's focus on ensuring flow out into the community from hospital, alongside sustaining individuals at home during winter is congruent with this goal.

5.2. Additionally, given the strategic plan's focus on supporting staff to deliver high quality services, the Winter Plan's focus on ensuring continuity of provision despite seasonal challenges is very relevant.

6. Management of Risk

INTEGRATION JOINT BOARD

6.1. Identified risks(s)

There are significant risks, both operational and reputational, for the Partnership if it does not have an accurate, comprehensive, and realistic Winter Plan. This includes:

- Delay/failure of service provision and inability to meet organisational and statutory responsibilities.
- Increased costs due to last minute spending to ameliorate system failures and capacity issues.

6.2. Link to risks on strategic or operational risk register:

From the Partnership's Strategic Risk Register:

"There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services."

This is currently graded as a "High" risk on the Strategic Risk Register.

6.3. How might the content of this report impact or mitigate these risks:

If the Partnership has an appropriate Winter Plan, it offers the opportunity to mitigate and manage predictable risk in a considered manner. This would therefore improve service delivery in difficult periods and minimise unexpected and/or unplanned costs.

It should be noted that presently the risk of "insufficient capacity" on the strategic risk register remains high, and that the measures outlined in the 2019/20 winter plan only offer partial mitigation of this. This is due to the

current pressures and capacity concerns within both the hospital and social care systems.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Aberdeen City Health & Social Care Partnership
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Surge, Capacity Planning and Festive Preparedness

Aberdeen City Health & Social Care Partnership 2019/20

Last Updated: August 2019

Action	Outcomes	Deadline	Update	Lead
RESILIENCE				
Initial Response for surge planning/resilience will be Senior Manager on Call with escalation to Chief Officer (as appropriate)	One point of contact with clear line of escalation to ensure decision making accountability. Clear and understood links between Senior Manager on Call and existing out of hours support arrangements.	In place.		Leadership Team
Ensure everyone aware of on call arrangements and rota	Senior Managers in the Partnership aware of on call arrangements and which senior staff are providing cover during Christmas and New Year.	On call arrangements to be locked by end of October 2019.		Business Manager

	This will include any 'deputising' arrangements for those managers who are on leave. Key contacts for all professions will be made available.	Key professional contacts already in Senior Manager on Call folder.		
Senior Manager On call folder is up-to-date, and contains accurate and relevant information for any immediate or emergency response required across the Partnership	Appropriate information is up to date in the Senior Manager On Call folder – allowing for timely and appropriate emergency response across Partnership services. This will include appropriate action cards etc.	In place.	**On Call folder was reviewed, updated and distributed to SMOCs, Chief Officer March 2019.** **Folder regularly reviewed and information updated as and when required.**	Buildings and Administration Team (for physical updating of material/folder) Senior Operational Leads (will determine material requiring updating)
Overall H&SCP business continuity plan reviewed annually	Business Continuity Plans (BCP): Services will undertake Business Impact Analyses including Surge Planning which will feed in to overall Community Health and Adult Social Care BCPs. This will ensure that BCP's are responsive to current circumstances and fit for purpose over winter 2019/20	Reviews to be complete by 31st October 2019.	**All services have now completed BIAs apart from Nursing + 2C GP Practices, however these should be available by the end of September 2019 at the latest.**	Partnership Business Manager (Partnership Wide)

Each service to have festive staffing requirements established by end of October 2019	Each service is clear regarding its staffing requirements over the winter period and has identified appropriate staff to ensure service continuity. Information shared appropriately across the H&SC Partnership and wider health and social care system [including social care providers]. Leave arrangements are coordinated appropriately across the partnership to ensure staffing levels can accommodate not only planned leave, but any contingencies (sickness etc).	Staffing requirements available for scrutiny by Leadership Team by 31st October 2019.	**Agreed at Leadership team on 24th July 2019.**	Senior Operational Leads
All staff (across the Partnership) are fully briefed on adverse weather policies	Ensures access to work maximised in poor weather for all relevant staff. Ensures consistent message relating to adverse weather is communicated to partnership staff.	In place.	**Procedures/process already in place.** **SMOC's are all subscribed to Met Office and SEPA alerts.**	Via NHS Grampian and Aberdeen City Council established process for adverse weather communication.
Winter Planning to be a standing item on key groups within the Health and Social Care Partnership	Risks monitored regularly and managed effectively via monthly Leadership Team.	From 31st October 2019.	**Agreed at Leadership Team meeting of 24th July.**	Leadership Team

Partnership actively participating in 'Care for People' group which reports to the Local Resilience Partnership.	Partnership fully integrated into any emergency planning and response arrangements.	In place. [6 monthly update to Chief Officer]	**Partnership representatives now sitting on group**	Senior Support Manager Partnership Business Manager
Partnership will review number and type of staff deployed to work on Public Holidays over the winter 2019/20 period.	Maximise staff available for immediate response + attempt to minimise the noted surge in demand that occurs post public holidays.	31 October 2019	**Relevant individual service areas currently reviewing.**	Leadership Team members
Partnership will systematically review its operational risk register prior to winter 2019/20 to highlight areas of difficulty/weakness.	Significant areas of risk that may impact on service delivery over winter 2019/20 will be identified and escalated to Senior Management for action prior to winter commencing.	31 October 2019	**The Leadership Team is currently reviewing its Operational Risk register, ensuring that the risks are identified through scrutiny of performance information data linked to the Strategic Plan.**	Business Manager Leadership Team
Partnership will review all GP practices using established RAG (Red Amber Green) risk assessment tool prior to winter 2019/20 to	Any significant GP Practice vulnerabilities that may impact on service delivery over winter 2019/20 will be identified and escalated to Senior Management for action prior to winter commencing.	31st October 2019	**Clinical Director confirmed this action will be undertaken again prior to winter 2019/20**	Clinical Director

highlight areas of concern.				
Partnership will timetable its workload and activities so that operational work is prioritised during winter surge period.	Non-operational workload for staff and managers will be reduced in times of peak demand – meaning resources are fully deployed to meet pressures and demand.	Throughout winter/surge period 2019/20 [primarily December 2019 / January 2020]	**Agreed at Leadership Team meeting of 24th July.**	Partnership's Leadership Team
Partnership will establish links with Aberdeen City Council's roads and footpath maintenance.	Ensures joined up and agreed priorities relating to winter road and walkway gritting.	In place.	**Partnership has contacted ACC Roads Operation Manager – will be in included in discussions around winter maintenance for 2019/20.**	Service Manager, Hospital Social Work

Action	Outcomes	Deadline	Update	Lead
COMMUNITY HEALTH				
Ongoing Participation in the Grampian Whole System Huddle	All stakeholders are clear about the state of play across the system and able to be proactive in the management of surges in activity. Escalate if necessary.	In place. [Daily weekday meeting]	**Partnership representation at huddle in place and ongoing.**	Head of Service, Specialist Older Adults and Rehabilitation
Older Persons Assessment and Liaison (OPAL) Team may be directed to areas of pressure in times of surge.	Good practice in relation to right place, right time, right person. Will support decision making about admissions and transfers. Will optimise synergies with Acute Care at Home now that it is operational.	In place. [Weekly review]	**Regular joint meetings of Partnership staff and Acute Unit Operational Manager with responsibilities for OPAL established for priority setting.**	Head of Service, Specialist Older Adults and Rehabilitation
Participation in robust discharge/flow planning as part of the NHSG Acute Unscheduled Care (6 Essential Actions) Group.	Resolution of structural matters relating to Unscheduled Care.	In place. [Monthly meeting]	**Partnership representation established at NHSG Unscheduled Care Group (both Grampian wide and Acute Specific).**	Head of Service, Specialist Older Adults and Rehabilitation Service Manager, Hospital Social Work
Partnership employed Pharmacy staff have	Clear arrangements are in place to prioritise key areas of service	In place.	**Confirmed with Lead Pharmacists that in**	Pharmacy Leads

an up-to-date and live "Prioritisation of services during pre-surge, surge and recovery" protocol.	delivery for pharmacy staff in times of surge.		**place and live ready for winter 2019/20**	
Acute Care at Home Team will use links with existing related services and offering of additional hours to staff to provide additional surge capacity if required.	Team will use existing 'workload sharing' arrangements with other services and sessional/bank/additional hours arrangements to provide additional support if significant demand pressures are noted.	In place.	**Confirmed with Acute Care at Home Team Leader on 10-07-2019**	Team Leader, Acute Care at Home
GP Practices set up to flex and offer additional "on the day" appointments based on actual demand fluctuations/surge.	Partnership will support GP practices to adjust proportion/volume of appointments to reflect the 'live' demand pressures during surge.	Ready to implement by 1st December 2019. [Weekly review during winter]	**Clinical Director has confirmed that GP's will deliver this on a practice by practice basis based on presenting demand.**	Clinical Director
Optimise Pulmonary Rehab (PR) capacity via: **- admin staff aligned to optimise fill rate** **- review of PR model and capacity** **- use of Technology Enabled Care to support PR**	Increase in PR class fill rates. Increase in PR participation and completion. Contribute to reduced admissions/reduced bed days for COPD conditions.	Ongoing from now until 31st March 2020	**Pan-Grampian Respiratory bundle supported for a further year 2019/20 by Chief Officers Group**	Partnership AHP Lead Partnership Physiotherapy Lead NHS Grampian Modernisation

West Visiting Service expanding to other areas of City.	Increase in capacity in primary care services/support as West Visiting Service expands to other locations.	As recruitment allows	**Recruitment underway for additional staff to support expansion**	Clinical Director

Action	Outcomes	Deadline	Update	Lead
SOCIAL CARE				
Provide interim bed capacity for hospital discharges during winter pressures.	Care Home Bed capacity (20 social care beds) reserved specifically to support discharges and improve flow out of hospital.	1st December 2019	**Bed capacity identified in care home sector for interim beds going forward from December 2019 onwards.**	Service Manager, Hospital Social Work
Vary allocation of interim social care beds to support cross system pressures.	Interim beds (which are dedicated to supporting discharge) can have their priority criteria varied to reflect cross system demand.	1st December 2019 [Daily review]	**Procedures governing allocation of interim beds will be updated again to confirm cross-system response to pressures.**	Head of Service, Specialist Older Adults and Rehabilitation Service Manager, Hospital Social Work
Provide interim Sheltered and Very Sheltered Housing properties to support hospital discharges	5 Very Sheltered Housing Flats will be reserved for those requiring support/care/accommodation on discharge from hospital.	1st November 2019	**Business Case for interim VSH drafted – approved by Executive Programme**	Service Manager, Hospital Social Work

during winter pressures.	Also exploring use of Sheltered Housing "Guest Flats" to support further flow out of hospital.		**Board on 14th August as start of approvals.** **Occupational Therapy staff currently reviewing sheltered housing guest flats for feasibility of use.**	
Care Home Business Continuity Plan Check/Review	A check that all care homes have in place appropriate Business Continuity Plans as per their contract, prior to any winter/seasonal pressures.	1st December 2019	**In progress.**	Partnership Business Manager (in conjunction with Aberdeen City Council Commissioning, Procurement and Contracts Team)
Prioritisation and Triage of all homecare provision for patients/clients.	Ensures that those in greatest need (including hospital-based delays) have any care at home capacity directed to them on a priority basis.	In place [Daily review]	**Arrangements now in place for staff to consistently triage and update client care requirements – ready for winter.**	Service Managers, Community Care Management
Provide 'step up' bed capacity within the care home sector to divert inappropriate prospective hospital admissions	Additional care home bed capacity reserved to support diversion from hospital – preventing inappropriate admissions at times of surge.	1st December 2019.	**Going out to market in August to see if there is interest from Care Homes in providing this.**	Service Managers, Community Care Management
Review of systems and opportunities for	Expected outcome would be better opportunities to meet	1st December 2019		Partnership Lead Commissioner

collaboration between independent and third sector providers and ACHSCP staff to identify opportunities to release capacity over winter.	identified need through release of capacity, providers working collaboratively to release capacity and ensure efficiency.			

Action	Outcomes	Deadline	Update	Lead
SEASONAL FLU, STAFF PROTECTION, AND OUTBREAK RESOURCING				
All Partnership staff have easy and convenient access to the seasonal flu vaccine – including access across work settings/employer – and are encouraged to avail themselves of it.	Reduction of staff absence due to flu.	As vaccine available.	**Link now established with Flu Advisory Group** **Pending decision still r.e. ACC staff flu access.**	All Partnership Managers Occupational Health Service Flu Advisory Group
Encourage targeted patient groups to access the flu vaccination.	Spread of the virus will be contained and influenza related demand will be reduced	As vaccine available.		NHSG Public Health and Primary Care
HSCP has an up-to-date 'Major Infectious Diseases Plan' which outlines HSCP actions / response in the event of a pandemic being declared.	Management of outbreak arrangements are responsive to current circumstances and fit for purpose over winter 2019/20	In place	**An exercise regarding Flu and prophylactic plans/triage will be put in place. This will include GP's. There would be demonstration regarding the software system that would be used/flu line etc. Invitations will be sent out to test system – potentially September 2019.**	Business Manager

			It was also agreed that all BIAs must include flu planning.	
HSCP has an up-to-date Mass Prophylaxis Centre (MPC) / Antiviral Collection Point (ACP) Operational Plan	Management of Prophylaxis and Antivirals is appropriate and responsive to any circumstances over winter 2019/20.	In place	**Awaiting information on National Flu Line via NHSG – NHSG organising exercise in September 2019 to test.**	Business Manager
Social Care voluntary and independent providers fully integrated into staff vaccination campaign	To ensure that all social care employers in the city are fully briefed and aware that their staff can access for free flu vaccinations via multiple routes (pharmacy etc)	In place.	**Link established with Flu Advisory Group to support social work/care contact.**	Service Manager, Hospital Social Work
Informal carers have free flu vaccination campaign promoted to them to support uptake.	To ensure that informal carers with Aberdeen City are aware that they can access the free flu vaccination.	31st October 2019	**Links made between Flu Advisory Group and VSA Carers Support Service – direct marketing and promotion to this group being put in place.**	Service Manager, Hospital Social Work
Appropriate Communications out to all Partnership Staff – r.e. not spreading infection etc	Ensures that the appropriate infection control messages go out to all partnership staff consistently (social care and health).	In place.	**Link established with Infection Control contacts to ensure that publicity messages go to all relevant staff.**	Service Manager, Hospital Social Work
Public Facing Communication for winter – expectations,	ACHSCP Staff, Partners and Public are aware of "Winter Plans" and able to take appropriate	October 2019	**ACHSCP awaiting content of national Winter Planning**	Business Manager

responsibilities etc. are customised for Partnership 'audience'.	preventative/preparatory actions e.g. flu vaccination.		**Campaign to co-odinate and support activity**	Senior Support Manager Partnership Lead Commissioner

Action	Outcomes	Deadline	Update	Lead
MANAGEMENT INFORMATION				
Daily management data collated for in-patient beds and intermediate care within the City Partnership to enable a real time 'handle' on flow; to facilitate escalation as appropriate.	Tracking of flow, unmet demand and an agreed threshold for formal escalation.	In place. [Daily weekday updates]	**In operation as of now.**	Head of Service, Specialist Older Adults and Rehabilitation
Regular identification of vacant care home capacity within the City + ability to increase checks on capacity when needed.	Weekly report on where, if any, there are places available in care/nursing homes to prevent hospital admissions and promote interim discharge arrangements. [Frequency of checks can be increased in times of surge]	In place. [Weekly updates as standard, but can vary based on demand/pressures]	**In operation as of now.**	Service Manager, Community Care Management Service Manager, Hospital Social Work
Weekly management data provided on volume of patients who are admitted/delayed in hospital + reason for delay.	Quick identification of flow issues relating to discharge delays + admission demand across the hospital estate. Escalation and reaction can occur quickly.	In place. [Weekly updates]	**In operation as of now.**	Service Manager, Hospital Social Work and Health Intelligence Staff
Regular review of H&SCP staffing status – vacancies/sickness	Identification of staffing issues at an early point + immediate forum to look at resolution of concerns.	In place.	**Agreed at Leadership Team meeting 24th July.**	Leadership Team

etc – via Leadership Team.	Sit reps for areas of concerns will be implemented if Leadership team feels needed – to be fed to monthly leadership meeting (or more frequently as needed).			

Action	Outcomes	Deadline	Update	Lead
SIGN OFF AND GOVERNANCE				
Appropriate sign off of finalised Winter Plan – via Chief Officer and the Aberdeen City IJB.	Winter Plan is given independent scrutiny and analysis	3rd September 2019	**To be reviewed by IJB on 3rd September 2019.**	Chief Officer Service Manager, Hospital Social Work
Review of the Winter Plan and its implementation will be via the Partnership's Leadership Team	Assurance is sought (and remediated if not available) that winter plan is appropriate to circumstances and is being implemented fully.	Commences October 2019 onwards	**Standing item in place as of October's Leadership Team.**	Leadership Team

Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
Senior Leadership Team (Partnership)	☒	G	Consulted via Leadership Team 24-07-2019 [Document confirmed and ratified at Executive Programme Board on 14-08-2019]
Nursing Leads / Medical Leads (Partnership)	☒	G	Consulted via Leadership Team on 24-07-2019
AHP Lead (Partnership)	☒	G	Consulted via Leadership Team on 24-07-2019
Pharmacy Leads (Partnership)	☒	G	Via Lead Pharmacists on 07-05-2019
Clinical Lead (Partnership)	☒	G	Consulted via Leadership Team on 24-07-2019
Mental Health Lead	☒	G	Consulted via Leadership Team on 24-07-2019
Lead Social Worker	☒	G	Consulted via Leadership Team on 24-07-2019
Chief Officer (Partnership)	☒	G	First draft passed to Aberdeen City Chief Officer on 26-06-2019. Also signed off as part of submission to IJB.

NHS Grampian	☒	**G**	First draft passed back to NHSG for consideration as part of their overall winter plan on 30-07-2019. Revised draft will be sent on for consideration as part of draft Grampian winter plan. Final approved version to be sent post IJB approval on 03-09-2018.

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	3rd September 2019
Report Title	Annual Report 2018-19
Report Number	HSCP19040
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Name: Alison MacLeod Job Title: Lead Strategy and Performance Manager Email Address: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	A. Annual Report 2018-19

1. Purpose of the Report

1.1. The purpose of this report is to obtain Integration Joint Board approval of the annual performance report for 2018-19 and its agreement that the approved report should be published and also presented to Aberdeen City Council and NHS Grampian for their information.

2. Recommendations

2.1. It is recommended that the IJB:

a) Approve the Annual Report 2018-19.

b) Agree that the Annual Report 2018-19 should be published on the partnership's website.

c) Instruct the Chief Officer to present the approved annual report to both Aberdeen City Council and NHS Grampian.

d) Instruct the Chief Officer to investigate the three areas for improvement i.e. the falls rate per 1,000 population aged 65+, the percentage of adults with intensive care needs receiving care at home, and the number of A&E attendances, and provide the Clinical and Care Governance Committee with an Action Plan for improvement of these indicators.

3. Summary of Key Information

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 obliges the integration authority to prepare a performance report for the previous reporting year which in this case is 1st April 2018 to 31st March 2019. The performance report therefore relates to the final year of the IJB's previous Strategic Plan.

3.2. The performance report must outline a description of the extent to which the arrangements set out in this plan have achieved, or have contributed to achieving, the national health and wellbeing outcomes.

3.3. Neither the legislation nor accompanying guidance prescribes a specific template to be used for the annual performance report. Each partnership can design its own format to best explain and illustrate its performance. The design of this year's report is based mainly on a very visual and easy-read format which has previously been encouraged by members and is hoped will grab the reader's attention and easily highlight areas of good practice and improvement. Most of the numerical data is contained in appendices.

3.4. The partnership's Performance Management Framework outlines core national indicators which are aligned to the national health and wellbeing outcomes. These indicators are consistent across Scotland and our own progress can be monitored not only against previous years but also against the Scotland average. At the national Strategic Commissioning and Improvement Network it was suggested that all partnerships report these in a similar format for ease of benchmarking. This year's Annual Report therefore has these indicators listed in the appendix to the main report.

3.5. In relation to the national indicators it has been previously noted that national indicators 1 to 9, which are based on a bi-annual survey using a random selection of recipients from GP practice lists, do not necessarily represent the views of people who use our services. In order to capture these views, a local survey has been commissioned, the target sample being people who have used both social care and health services provided by the partnership. The first of these surveys commenced in June 2019 and we should have the

results by September 2019. Although the information in the current Annual Report is based on the national survey, we will use the results of the local survey for next year's report. The local survey will be repeated in 2021.

3.6. This year, in relation to the national indicators we have been informed that there is an issue around data completeness for performance statistics against national indicators 12, 13, 14, 16 and 20 as they relate to the financial year 2018-19. Every partnership has therefore been advised, in order to ensure robust benchmarking, to report data for these indicators on a calendar year basis and we have done so in our report.

3.7. Previously we had a suite of local operational indicators aligned to key themes - Safe, Effective, Responsive, Caring and Well-Led. Data was not consistently collated and reported on these, but information has been provided in the Annual Report where it is available. A new set of local indicators aligned to the refreshed Strategic Plan were approved by the IJB in December 2018 and these will feature in future performance reports.

3.8. In addition, we have been asked by the Ministerial Steering Group (MSG) to report on a number of indicators which they feel best demonstrate progress on integration and which can be benchmarked across Scotland.

3.9. The partnership's performance against all of these indicators – national, local and MSG - are outlined in the Annual Report and an analysis and commentary has been provided on indicators of note. In addition to the quantitative data, this year a section entitled "That was the year that was" has been added capturing the qualitative information relevant to the year.

3.10. The partnership's Chief Finance Officer has provided regular budget monitoring updates to the IJB throughout the year. The annual report includes an overview of the total amount of money spent and also the total amount and proportion of spend in the reporting year broken down by the various services to which the money was allocated. This information mirrors that contained in the partnership's audited accounts for 2018/19 which were presented to the Audit and Performance Systems Committee.

3.11. This year again, we have included a section about Looking Forward which captures the areas of improvement that we are aware of and the many areas of good practice currently under way. We hope to be able to further report on these in future annual reports.

3.12. Highlights for this year's Annual Report are:

- continued improvements in Delayed Discharges
- reduction in admissions to A&E
- implementation of a number of strategies
- progress on a number of transformation projects
- stabilising our governance and structure arrangements
- approval of our Workforce Plan.

Some areas for improvement include:

- falls rate per 1,000 population aged 65+
- percentage of adults with intensive care needs receiving care at home
- number of A&E attendances.

Our falls rate per 1,000 population aged 65+ has worsened by 13%. As we remain the same as the Scottish average it has not been highlighted as a "red" indicator; however, it is an area of concern for us and we are treating it in the same way as the two red indicators. We are actively investigating the reasons why the three areas above have shown declining performance and will take action where appropriate to aim for improvement in future. The IJB is asked to instruct the Chief Officer to investigate performance in these areas and provide the Clinical and Care Governance Committee with a report on her findings. This is in line with the approach taken last year in relation to readmissions to hospital after 28 days.

3.13. The integration authority is required to publish this annual performance report and to provide a copy of it to its constituent authorities, Aberdeen City Council and NHS Grampian. The Integration Joint Board is therefore being asked to approve the Annual Report 2018-19, its publication and sharing with ACC and NHS Grampian.

3.14. The Annual Report 2018/19 is set out in Appendix A.

4. Implications for IJB

4.1. Equalities – the annual report demonstrates the positive impact health and social care services is having on people with some protected characteristics such as age, disability etc.

4.2. Fairer Scotland Duty – this report has no direct implications in relation to the Fairer Scotland Duty, it does however, demonstrate positive impacts in relation to tackling health inequalities.

4.3. Financial – there are no direct financial implications arising from the recommendations of this report.

4.4. Workforce – there are no direct workforce implications arising from the recommendations of this report.

4.5. Legal – under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 we have a statutory obligation to publish an Annual Report. Whilst, due to governance arrangements we are unable to publish within the stipulated timescale (four months after the end of the financial year i.e. 31st July 2019), we are in a similar situation to many partnerships and there is an acceptance at government level that this is the case. If the Annual Report was not to be approved and published, we would be in breach of our legal obligation which would damage the reputation of the IJB and give rise to uncertainty around its performance.

4.6. Other – none.

5. Links to ACHSCP Strategic Plan

5.1. The Annual Report demonstrates the progress made in the final year of our previous Strategic Plan.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that we breach our legal obligation under the Public Bodies (Joint Working) (Scotland) Act 2014 (as described at 4.5 above) and also that we are not transparent and open about our performance.

6.2. Link to risks on strategic or operational risk register:

This report links to strategic risk 5. - *There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally determined performance standards as set by the board itself. This may result in harm or risk of harm to people*.

6.3. How might the content of this report impact or mitigate these risks:

INTEGRATION JOINT BOARD

The report gives the IJB assurance on the areas where we are performing well and highlights areas where performance could be improved allowing them to direct remedial activity where required.

Approvals	
	Sandra Ross (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Annual Report 2018-2019

Aberdeen City Health & Social Care Partnership

A caring partnership

NHS Grampian

ABERDEEN CITY COUNCIL

Aberdeen City
Health & Social Care
Partnership
A caring partnership

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This document is also available in large print, other formats and other languages on request.

Please contact Aberdeen City Health and Social Care Partnership on 01224 523237 or ACHSCPEnquiries@aberdeencity.gov.uk

For help with language / interpreting and other formats of communication support, please contact 01224 522856 / 522047

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1. Introduction

"We are a caring partnership, working in and with our communities to enable people to achieve fulfilling, healthier lives"

Our annual report outlines how effective the Aberdeen City Health & Social Care Partnership (ACHSCP) has been in 2018-19, the final year of the partnership's first Strategic Plan which was published on integration 'go-live' in April 2016. It describes our progress against a range of local and national performance indicators and reflects on the impact of the day-to-day delivery of our integrated health and social care services. Our performance management is a work in progress, and we are continually looking to improve the content and method of our performance reports.

Our third year of operation as an integrated partnership continued the progress of previous years in improving the experiences and outcomes of the people who use our services and their carers. We recognise that our services are not yet as well co-ordinated and collaborative as we would like them to be and there is still much to do before we have truly transformed service delivery across the partnership.

We have confidence in the capability of staff in all areas of the partnership, including our third and independent sector partners, not only to ensure that a good-quality, person-centred service is being delivered on a day-to-day basis, but also to offer their professional insights about what we could be doing differently. Our aim remains to continue to be known and respected as a high-performing partnership that has a reputation for its compassion, quality, innovation and effectiveness.

The partnership's second Strategic Plan was approved by the Integration Joint Board (IJB) in March 2019 following comprehensive engagement and consultation with the people who use our services, their carers, communities and other appropriate stakeholders.

The IJB continues to exercise good governance and oversight of the partnership's activities. It has made clear its expectations about the implementation of our strategic plan, the delivery of the expected benefits of our transformation programme and the desired positive impact on the health and wellbeing of our local population, including our wider partnership workforce.

We are committed to the integration of health and social care services and working collaboratively with our partners to achieve desired outcomes. We would like to thank all our staff and volunteers in every partnership service for striving on a daily basis to make a difference. It is hugely appreciated, and their hard work and commitment does not go unrecognised.

2. Analysis and Commentary on Indicators of Note

In relation to the statistics in Appendix A, the available information enables us to compare the partnership's performance in the past year with the previous year, to compare against the country's performance as a whole, and to show its position relative to the other partnerships in Scotland for each indicator. Aberdeen City sits in the country's top 20 partnerships for 15 of the 19 reported indicators.
We know we can do better and our expectation is to improve our performance across all indicators year after year.

In Figure 3.1, the red line indicates the previous reporting period and the bars demonstrate our performance change.

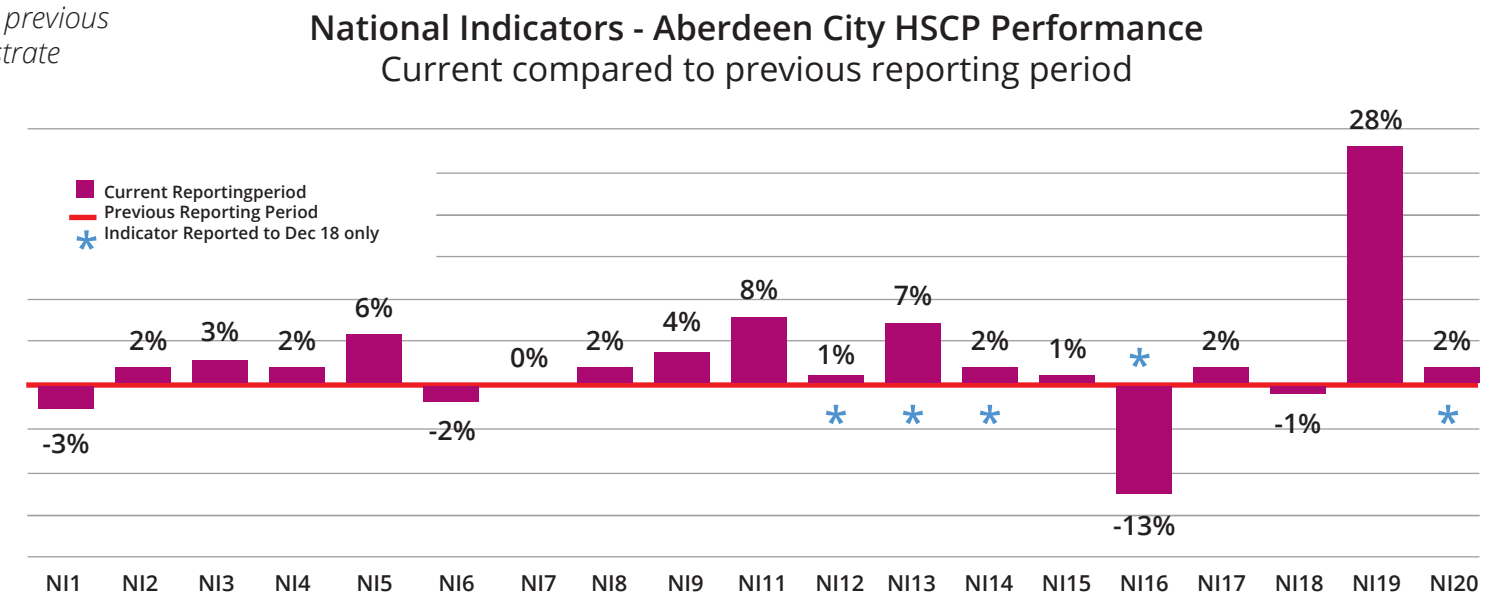


Figure 3.1 ACHSCP Performance (National Indicators) Compared to Previous Period

Fifteen of the 19 reported indicators have improved or stayed the same, since the previous reporting period. This is an improvement on last year where 14 indicators improved or stayed the same. Of the four indicators that performed worse than the previous period, three were on or within 3% of the previous performance except NI.16 – Falls rate per 1,000 population aged 65+, where performance had worsened by 13%, however Aberdeen City's performance remains the same as the Scotland position of 17 falls per 1,000 population aged 65+

In Figure 3.2, below the red horizontal line shows the national position and the bars for each indicator show the percentage by which the partnership differs from Scotland's performance for the current reporting period. Positive bars show where the partnership is performing better than Scotland and negative bars show where our performance is worse than Scotland's.

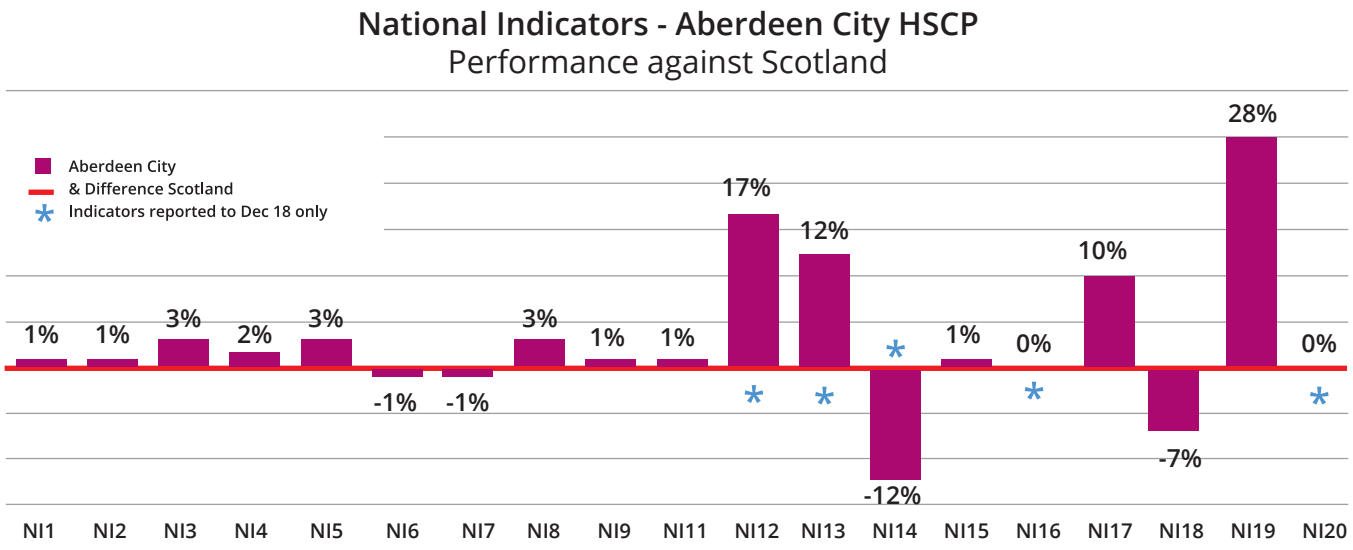
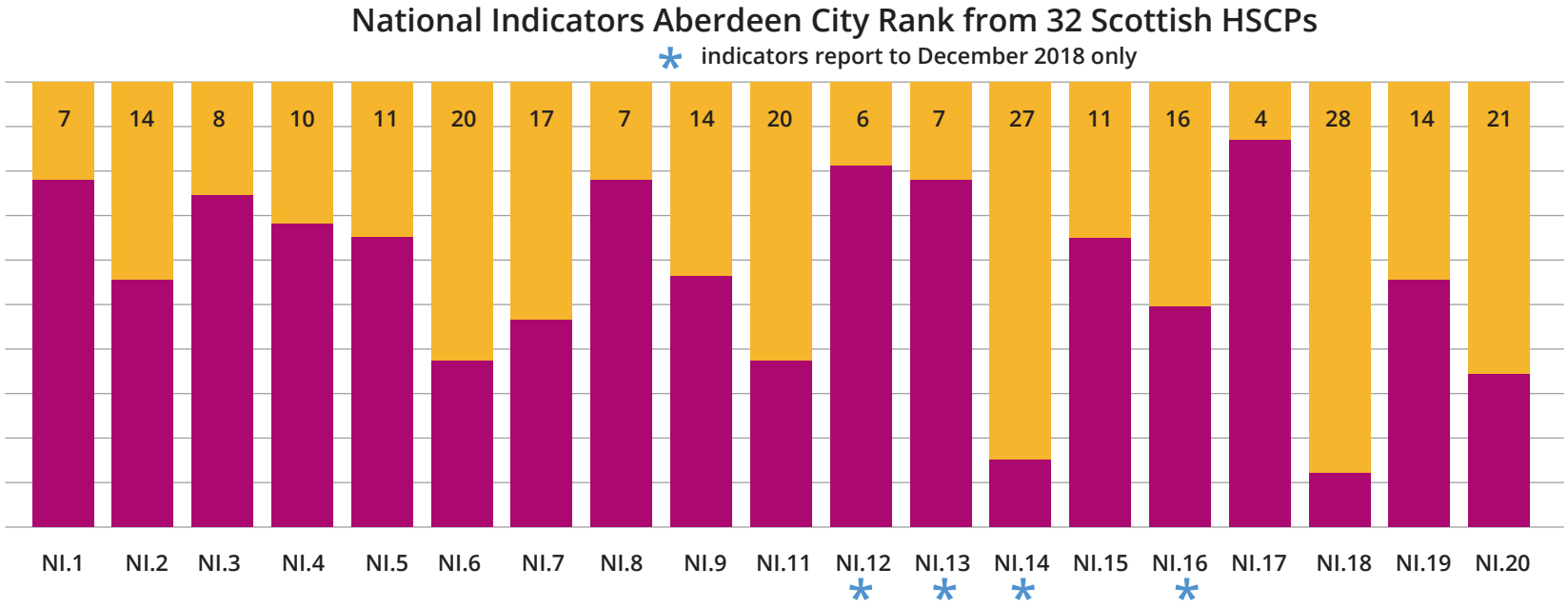


Figure 3.2 ACHSCP Performance (National indicators) Against Scotland

For the current reporting period the partnership performed better than Scotland for 13 of the 19 national indicators; this is an improvement from last year where we performed better in 12 of the 19 national indicators.

We performed worse than Scotland in four indicators; all were within 5% of the Scotland figure with the exception of NI.14 - Readmission to hospital within 28 days (12% worse than Scotland) and NI.18 - Percentage of adults with intensive care needs receiving care at home (7% worse than Scotland).

Figure 3.3 shows the partnership's performance for each indicator ranked against all the other partnerships in Scotland. A lower number demonstrates a better position against the rest of Scotland. Aberdeen City was in the top 50% for 13 of the 19 reported indicators for this reporting period. This is an improvement from the last reporting period where Aberdeen City reported 11 of the 19 indicators in the top 50%.



The percentage of staff who say they would recommend their work-place as a good place to work is not reported nationally however we have taken the data in Appendix A from NHS Grampian's iMatter survey which covers all partner-ship staff including those employed by Aberdeen City Council.

In 2018/19 ACHSCP participated in a self-evaluation exercise organised by the Ministerial Steering Group in relation to demon-strating progress on integration. Overall the partnership result was positive: -

45% rated at Exemplary level
41% rated at Established level
14% rated at the Part Established level
0% rated at the Not Yet Established level

Areas of improvement were identified, and an Action Plan has been developed which will be monitored by the Leadership Team with progress report-ed to the IJB in March 2020. It is anticipated the self-evaluation will be repeated in future years and our aim will be to achieve 100% at Exemplary level.

Admissions from A&E have reduced by 5.5% since 2016/17 and are almost 23% lower than the Scottish figure.

The emergency bed day rate has reduced significantly by almost 11% since December 2016 and is over 12% lower than the Scottish figure which is likely impacted by our improved delayed discharge activity.

National Indicators 1 – 9 are based on a bi-annual survey of individuals who are registered with GP practices. The recip-ients of the survey are randomly selected from the practice lists. There is no targeting of people who actively use health and social care services, but this is one of the first questions asked in the survey so we can identify what percentage of respondents do. Return rates are generally poor and an analysis of these, combined with those who confirmed they have used services indicate that responses are reflective of an extremely small number of service users – less than 1% in 2015/16.

Whilst these figures are reported nationally, we are obliged to reflect them in our annual report; however, we will not undertake any in-depth anal-ysis on these. In June 2019 we commissioned a local survey with a view to gathering more representative data. The questions in the local survey reflect national indicators 1 to 9 and more and we will report on the outcome of that in next year's annual report. The local survey will be repeated in two years' time in order that we can measure progress.

The premature mortality rate has decreased significantly from 464 in 2015 to 423 in 2017 and is lower than the Scottish rate of 425 in 2017. We hope this trend will continue particularly with the implementation of some of our prevention and resilience initiatives in relation to promoting healthier life-styles and greater self-management of conditions and look forward to the publication of subsequent year's data.

The proportion of care services graded 'good' (4) or better in Care Inspectorate inspections has increased again from 86% in 2016/17, to 90% in 2017/18 and now to 92% in 2018/19, significantly higher than the Scottish average of 82%.

We believe this is indicative of the improved working relationships we have developed with local providers along with our commitment to ensure the Scottish Living Wage is paid to all adult social care workers.

The number of delayed discharge bed days has reduced by 33% in the last two years and is 14% lower than the Scottish figure. This is as a result of positive collaborative working between the Discharge Hub, colleagues in ACC Housing and commissioned providers.

A&E attendances, having dropped the previous year have increased again in 2018/19 and are above the Scottish average. We will continue to work towards diverting demand away from A&E through our Link Practitioners, Action 15 and Primary Care Improvement Plan and the introduction of our Mental Health, Dementia and Social Isolation Delivery Plans.

The number of unscheduled hospital bed days for both acute and long stay specialties has reduced significantly by 20% each since 2016/17.

We attribute this improvement to the work ongoing in relation to delayed discharges, improving the throughput of patients generally.

The number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) has continued to drop as a result of positive collaborative working between the Discharge Hub, colleagues in ACC Housing and commissioned providers. The figure has gone from 1,155 days in 2016/17, to 838 days in 2017/18, and 605 days in 2018/19 – a reduction of almost 48%. Aberdeen City's 2018/19 figure is almost 25% lower than the Scottish figure of 805 days

The readmission to hospital rate of 115, although lower than last year's figure of 117, is still higher than the previous year's figure of 104 and the Scottish figure of 103. This area is subject of ongoing investigation by our Unscheduled Care Group.

The percentage of adults with intensive care needs receiving care at home dropped last year to 54% from 55% the previous year and is significantly lower than the Scottish figure of 62%. Comparison with the Scottish figure is artificial as historical practice differs greatly between each local authority area. The local drop is concerning however and the reasons for this will be investigated and analysed.

3. That Was the Year That Was

2018-19 was busy with many different activities, developments and initiatives.

These highlighted the diversity and complexity of the partnership's delegated functions and services being progressed or completed.

The partnership's Carers Strategy, **A Life Alongside Caring**, was approved by the IJB in March 2018 and formally launched in Carers Week in June that year.

The implementation of this strategy alongside the introduction of Adult Carer Support Plans and Young Carer Statements is helping to meet many of the hopes and aspirations that carers themselves have told us about, like: treating carers as equal partners in care; treating carers holistically; improving support; building trust; planning for the future; co-ordinating the support provided to a carer, and recognising the impact of the caring role.

The partnership's Learning Disability Strategy, **A'thegither in Aberdeen** was launched in May last year at Pittodrie Stadium.

The then-chair of the IJB, Jonathan Passmore said that this was *"the clearest, simplest and most accessible document the IJB had ever seen".*

The strategy recognises that people with learning disabilities are valued contributors to our communities and it maps out how we can help them to flourish and achieve fulfilling, healthier lives.

The **Autism Strategy and Action Plan 2019-2022** was approved by the IJB in December 2018.

This whole-life strategy has been created in partnership with autistic people, families, professionals and organisations and reflects the revised Scottish Government outcomes and priorities.

It outlines the underpinning strategic vision and the actions across 13 focus areas that will deliver improved outcomes and experiences for the local autistic population.

Some of the highlights from the past year include:

2018-19 saw the departure of our interim Chief Officer, Sally Shaw, who was successful in obtaining the Chief Officer post in the Orkney Islands.

Sandra Ross was appointed by the IJB to be its Chief Officer in August 2018.

"At the time, IJB Chair Jonathan Passmore said: *"We are delighted to welcome Sandra into Aberdeen City Health & Social Care Partnership. She brings a wealth of experience of front-line service, which will be of great value to the organisation."*

Having worked for a range of organisations, Sandra has extensive knowledge of operational management, and will bring strong leadership skills to the organisation as we continue to reshape and transform adult health and social care in the city.

Sandra Ross
ACHSCP Chief Officer

One of the Enablers in our new Strategic Plan is an Empowered Workforce. In March 2019 our IJB approved our Workforce Plan, which was co-produced with a wide variety of stakeholders and staff groups. The plan seeks to ensure a sustainable workforce with the right skills and behaviours. It acknowledges that in order to achieve the identified objectives, there is a need to:

- fundamentally change what is done, the way it is done and with whom to fully integrate services
- increase engagement of the workforce, in its widest sense, by making them feel more valued
- support staff's well-being (physical & mental)
- make work a joyful thing and increase trust with colleagues and partners

In developing the plan, we considered some of the key challenges such as an ageing population; an ageing workforce; increasing complexity; and lack of digitalisation. These challenges point to a need to engage in the potential of younger people, in order to have appropriate succession planning in place.

The need to retain and train people to support the transformation of the way support is delivered is also required.

Underpinning the delivery of the workforce plan is an action plan based upon four themes; **Right People, Right Skills, Right Roles, and Sustainability**.

Dr Caroline Howarth MBChB FRCGP was appointed as the new Clinical Director for Aberdeen City Health & Social Care Partnership in January 2019.

Caroline became cluster lead for the Central South GP Cluster in 2013 and went on to became one of the deputy clinical leads for the partnership in 2016.

She has been involved in many projects across the city, including the recent and very successful West Visits Unscheduled Care initiative. She is currently leading on implementing the Primary Care Improvement Plan across Aberdeen.

Integration Joint Board Chair Councillor Sarah Duncan said:

"*I am delighted that Caroline is joining the partnership's Leadership Team. She has a wealth of experience in the delivery of primary care services for the people of Aberdeen and has already demonstrated her strong leadership skills through her prominent role with professional GP bodies and in key partnership initiatives.*"

Aberdeen City Health & Social Care Partnership
A caring partnership

The Acute Care at Home (AC@H) service seeks to provide comprehensive assessment and care to frail elderly people in their own homes during an acute phase of illness where it is safe and appropriate to do so. The service pathway supports both Admission Avoidance (GP referrals initially) and Active Recovery, for those patients who have received assessment, diagnostics and acute treatment.

The evaluation shows that the service appears *"no less safe than usual care"* and satisfactory to patients, unpaid carers, staff and interacting organisations.

In this period there were a total of 84 admissions to the service, most of which were from the Geriatric Assessment Unit (GAU) using the early discharge model (67%) and consisted of older adults with frailty requiring support following hospital discharge.

In comparison to a GAU admission, 2.5% more patients were living at home 90 days following AC@H discharge and 6.8% lower mortality rates were reported.

The West Unscheduled Visiting pilot scheme to help GP practices deliver an afternoon home-visiting service has proved a big success.

All the locality's seven GP practices and Grampian Medical Emergency Department (G-MED) took part in the initiative, which involves an Advanced Nurse Practitioner (ANP) visiting patients who ask for an unscheduled home visit that would usually have been undertaken by a GP.

GPs were very satisfied with the service, giving it an average score of 90%. They reported reduced workloads, allowing them to spend more time with patients in the practice, a high-quality service for patients, and decreased stress for other practice staff. ANPs felt they provided holistic care to patients and were providing the practices with a good service.

Patients who returned questionnaires at the end of the evaluation period also reacted positively, with 100% of respondents rating their ANP as "very good" for their compassion and respectfulness. Respondents also gave the scheme full marks in terms of their overall satisfaction. One patient told the evaluation team:

> *"The home visit was excellent – the nurse was very good and patient with me. I wish we could get someone like her all the time."*

The findings have been published in the Journal of Research in Nursing, available at: *https://bit.ly/30yjvUo*

The partnership is now extending the service – with the longer-term aim of scaling up the model to cover half of the city by the end of this year.

Aberdeen Links
Connecting local communities

The partnership undertook an evaluation of our Integrated Neighbourhood Care Aberdeen (**INCA**) pilot to show how well our two teams of community nursing and care at home staff in Cove and Peterculter had fulfilled key Buurtzorg principles, namely – keeping the person at the centre, drawing on and building informal networks to support them, working in small self-managing, neighbourhood-based teams, collaborating with formal networks as required, and using an enabling approach rather than a narrow focus on time and task.

Our evaluation of this pilot showed that:

- *people receiving their support from INCA greatly valued the service (mean satisfaction score 98%)*
- *staff retention was challenging, particularly regarding self-management, resolving conflict and a predominantly social-care caseload (due to the team's double-running with existing community nursing teams)*
- *a real positive was the ability to rapidly provide step-up or step-down support according to a person's individual and changing needs.*

Whilst the pilot has come to an end, our learning from it is being embedded in our overall approach to service delivery which will improve our provision of flexible, person-centred and enabling care and influence the development of a multidisciplinary team approach to the rapid stepping up and down of support in localities

The Aberdeen Links Programme went live in September 2018 with the recruitment of the first cohort of Primary Care Link Practitioners by our commissioned partner, the Scottish Association for Mental Health (SAMH). This initially covered two thirds of the practice population with a second and final cohort commencing the following year.

The aim of the programme is to support people to live well through strengthening connections between community resources, third sector organisations and primary care and to enhance social prescribing activities in Aberdeen.

The programme recognises the demand for GP and other primary care services and introduces an opportunity to integrate a different skill-set into the practice team.

Link Practitioners are providing a person-centred service that is responsive to the needs and interests of the practice population by supporting patients to identify issues that affect their ability to live well and help them to address these.

The INCA evaluation, referenced above, was used as the basis for a research article by the partnership's Research and Evaluation Manager, Dr Calum Leask, in conjunction with a colleague, Andrea Gilmartin from NHS Grampian.

This article was published in a peer-reviewed and internationally read journal, AIMS Public Health.

It is the first peer-reviewed piece of research that the partnership has produced and as such is hugely significant for emphasizing to a global readership the partnership's outcome-focused ambitions and priorities

The Capital and Services Team were worthy winners of this year's 'Team Aberdeen' HEART award. They are currently progressing a number of live projects which are aligned to key investment priorities in the NHS Grampian (NHSG) Primary Care Premises Plan 2019-2020, including:

Denburn / Aurora Project: An Outline Business Case has been approved to secure £8.1M investment to accommodate the Denburn/ Aurora Medical Practice in a new Community Treatment and Care Centre.

Counteswells: The IJB together with NHSG and ACC are exploring opportunities for the co-location of health and care services with Education, Community Learning and other community planning partners in a wider community campus model in the emerging Countesswells community.

Danestone: Work is ongoing to secure investment for the replacement of the Danestone Medical Practice to better support new models of care and introduce new professional roles across the North Locality.

The North Corridor: The Aberdeen City and Aberdeenshire IJBs, together with NHSG, are progressing an Outline Business Case to secure £19M to deliver an integrated Community Treatment and Care Centre for 13,000+ patients.

The Team are also working with colleagues to develop an Infrastructure Plan by January 2020. This plan will set out strategic priorities to invest in buildings, ICT, equipment and transportation links to ensure a modern, flexible, accessible and connected estate.

During 2018/19 we progressed a number of digital initiatives to enhance the way we work.

'Connect', the partnership's dedicated intranet, was launched in January 2019 providing a space for a range of news and information of interest to staff, from copies of the 'Partnership Matters' newsletter,to guidance documents, to social spaces and how staff can have their say.

Your News | Your Info | Your Space
connect
A Caring Partnership

Links to Connect are also available on the NHS Grampian Intranet and Aberdeen City Councils Intranet the Zone. The GOVRoam project which gives secure wifi access across ACC and NHSG premises has been made live. This means NHS staff will have network access in places such as Marischal College and ACC staff in all NHS premises.

This is part of a much wider project across Scotland so that eventually staff will have access to secure WIFI in any publicly owned building right across Scotland irrespective of the sector of local government or NHS staff work in.

A project, which was initially aimed at giving the Link Practitioners internet access at GP practices, was further widened to all NHS buildings in Aberdeen city so that staff from any of our third sector partners can have internet access while carrying out duties at NHS buildings throughout the city.

Aberdeen City Health & Social Care Partnership

A caring partnership

During 2018-19,73 initiatives were funded through the **Health Improvement Fund** to improve health and wellbeing in communities across Aberdeen.

Projects funded have ranged from developing a woodland walk to be more accessible for the whole community; to raised beds at sheltered housing; to creating a sensory garden within a local primary school.

A celebration event was held for the first time in November 2018 as an opportunity for projects to share learning and network.

Eleven projects attended to showcase their work with approximately 80 staff and community members attending.

The learning from this has been used to shape further showcasing opportunities.

The Health Improvement Fund has continued to evolve by continuing to grow the decision-making process involving more frontline staff and community members. The fund has also undergone an options appraisal process to inform the future direction of the fund.

A report was presented to the IJB in March 2019 sharing the journey of the fund from 2016-19.

https://www.aberdeencityhscp.scot/our-news/new-report-highlights-heath-improvement-fund-successes/

Co-production aims to draw on the knowledge, ability and resources of people along with professionals to improve outcomes. Aberdeen City Health and Social Care Partnership decided to test out co-production approaches and worked with Governance International where staff and community members were familiarised with the Co-production Star toolkit. Locality-based projects were developed, including a focus on diabetes peer support in the South and falls prevention in the North.

The approaches supported the development of 'Stepping Forward Together' to help people self-manage their falls risk. As a result of listening to stories from service users the concept of 'falls ambassadors' emerged, their role being to visit community groups to share personal experiences, talk about ways to prevent falls and demonstrate strength and balance exercises. The ambassadors working with Occupational Therapy staff tested out this approach on a number of groups and following positive feedback applied for Health Improvement Funding to develop a model that would become sustainable.

A peer support group meeting eight-weekly at Robert Gordon University (RGU) for people living with Type 2 diabetes is another initiative that has been co-produced with the community and various partners. The Health Improvement Fund has played a key role by starting a series of development and training activities. These were identified by members of the community to develop their confidence as Peer Supporters and to sustain the peer support model in their neighbourhoods and across networks.

Audit Scotland published its **Health and social care:** update on progress report in November, which assessed the success of health and social care integration in Scotland so far.

The report highlighted leadership, information-sharing and governance as key strengths of the Aberdeen City Health & Social Care Partnership.

We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the Partnership.

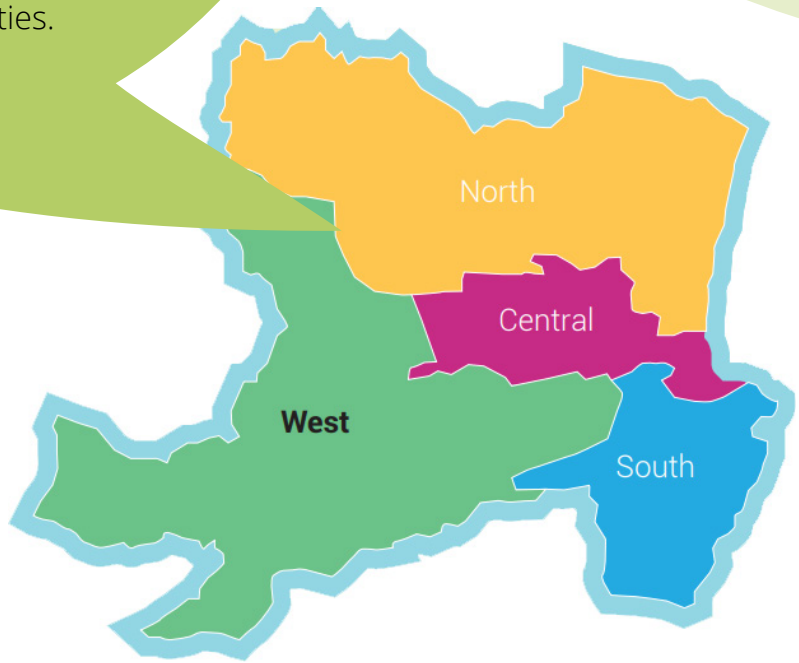
Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes

At its meeting in March, the IJB agreed to move from four to three localities – to help **Aberdeen City Health & Social Care Partnership (ACHSP)** provide services tailored to the needs of local communities.

Each of the three new ACHSCP localities will include within its defined area an Aberdeen Community Planning Partnership priority locality – and the three localities will be aligned with existing city neighbourhoods.

During a comprehensive consultation on the proposal to move to three localities, respondents were overall in favour of the change and overwhelmingly agreed that more joined-up locality planning arrangements would bring big benefits.

The new arrangements will be brought in over a period of time and the approach will be very much based on working closely with interested people, groups and communities.



In January 2019, Independent Sector Leads from Scottish Care's Aberdeen City team met with managers from 18 out of 20 independent sector care homes in the city. The aim was to:

- scope current communication and involvement with ACHSCP
- learn about local independent care homes workforce and practice development
- gather information regarding the relationships between care homes and external organisations
- identify any next steps.

A report, "Voices from the Independent Sector CareHomes", was produced in March 2019 and this has identified areas where the partnership can work together with the independent sector to improve working relationships and ultimately positively impact outcomes for our clients, resident in carehomes.

The HEART Awards – ‘Having Exceptional Achievement Recognised Together’

– was designed to celebrate the outstanding work of colleagues in ACHSCP and its partner organisations.

Our third HEART Awards ceremony was held at the Beach Ballroom in March 2019 and the occasion drew some 350 colleagues for an evening of home-grown entertainment and accolades.

The award winners were:

The Hearing Others Award:	Anne Carmichael & Peter Stephen
The Empowering People Award:	Dr Susan Brechin
The Team Aberdeen Award:	Capital & Services Team
The Rising Star Award:	Katharine Paton
The Beating Heart Award:	Dr Alasdair Jamieson
The Staff Choice Award:	Mark Craig
Special Commendation:	Dr Claire Wilkie

4. Our Local Framework

Aberdeen City Health & Social Care Partnership
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The local performance management framework we had in place under our previous Strategic Plan had five themes (**Safe, Effective, Responsive, Caring and Well-Led**), each with its own set of locally agreed operationally focused measures. The framework gave us a baseline for improving the experiences and outcomes of the people who use our services and their carers and this chapter of our Annual Report provides the final update against this format.

With the development of our new Strategic Plan we have devised a new performance framework with a number of measures allocated across each of the five Strategic Aims – Prevention, Resilience, Personalisation, Connections, and Communities. The measures are noted in the final section of our Strategic Plan. Future Annual Reports will contain detail on our progress against these but in the meantime here are some of the highlights from the final year of our previous strategic plan.

SAFE: How well do our services protect people from abuse and avoidable harm?

The partnership recognises its responsibilities to keep people and communities safe from harm.
Referrals to Adult Support and Protection and the number of complaints received are good indicators as to how well we are doing in this regard.

Adult Support and Protection	**2016-17**	**2017-18**	**2018-19**
Referrals to Adult Support Unit	1203	1125	1367
Referrals requiring further adult protection action	34%	36%	34%
Referrals requiring further non-adult protection action	20.5%	22%	27%
Referrals requiring no further action	45.5%	42%	28%

Note, 153 outcomes are still as yet unknown.

The increase in referrals is seen as a positive in that more people are aware of Adult Support and Protection legislation and are willing to come forward with any concerns they may have. Those referrals requiring further adult protection action decreased last year and it is positive to note that an increase in referrals resulted in further non adult protection related action meaning that this process is helping us to identify and meet the needs of our vulnerable clients whatever these may be.

Complaints	**2017-18**	**2018-19**
Stage 2 Total Received	108	93
Stage 2 responded to within timescale	68%	72%

NB: due to anomalies with recording we are only able to report complaints received for the last two years. The number of complaints has decreased which indicates an increase in satisfaction levels whilst the rate responded to within timescale has increased which demonstrates how seriously we take poor individual experiences and outcomes.

Effective: How well does our care, support and treatment achieve good outcomes for individuals?

Smoking is a major contributor to poor health. Our efforts have been to provide effective care by reaching people in parts of Aberdeen where smoking is still prevalent and support them to quit.

Alcohol Brief Intervention (ABI) is a preventative approach to support a healthier relationship with alcohol. In previous years, efforts have been focused on providing ABIs in healthcare settings and government targets are set in this way. We have, however, been increasing the volume of ABIs delivered in community settings

	2017-18	2018-19
Smoking Cessation (most deprived areas)	389	337
Number of ABIs delivered	4043	4471

There has been a decrease in smoking cessation in our most deprived areas. Changing priorities and the needs of a more complex 'hard to reach' client base has meant a shift of focus away from the community to more acute settings which has disrupted service provision. In line with national trends, there are also less smokers presenting to the service. It is thought this is due to the rise of the use of e-cigarettes as a quitting aid as well as the challenges we have yet to overcome in reaching some client groups who are not accessing services.

There has been a significant (more than 10%) rise in the number of ABIs delivered. A reduction in the harmful impact of alcohol, tobacco, drugs, obesity and poor oral health is a commitment we have made in our revised Strategic Plan.

Responsive: How well are services organised to meet individual needs?

Being responsive to individual needs is a critical influence on people's experiences of using our integrated health and social care services. As reported earlier, there has been a decrease in the number of delayed discharges and a significant decrease in the number of bed days occupied by those whose discharge has been delayed.

One of the strategic aims in our revised Strategic Plan is Personalisation, which is about delivering the right care, in the right place at the right time and the performance measures identified will help us demonstrate this more effectively in future.

Caring: How well, with respect to dignity, compassion and kindness, do we treat people?

The recently commissioned local survey aims to evaluate the impact of our deliverables within our strategic plan. Within this we also seek to understand people's satisfaction with health and social care services that we provide and whether we do so with dignity, care and respect. The results of the first survey which will be completed by Autumn 2019 will provide us with a baseline for improvement for when the survey is repeated in 2021.

Well-Led: How well do we encourage learning, innovation and an open culture?

A workforce that feels valued and supported is a crucial piece of the jigsaw of how we improve the experiences and outcomes of the individuals who use our services and their carers. In short, high employee satisfaction contributes to improved user experiences and outcomes.

Promoting trust and autonomy is a key behaviour of a modern, adaptive organisation and one which will lead to improved staff morale and welfare. In March 2019 our IJB approved our Workforce Plan which was co-produced with a wide variety of stakeholders and staff groups. The plan seeks to ensure a sustainable workforce with the right skills and behaviours.

Our HEART Awards, our annual conference, the iMatter tool and the Chief Officer's regular 'Open Forum/'Meet the staff' focus groups and the development and launch of our new 'Connect" intranet site for staff in January 2019 are all great examples of the partnership's commitment to engage, motivate and inspire staff to do their very best each and every day.

2018/19 saw changes in our senior management structure. Our new Chief Officer, Sandra Ross started in September 2018 and, taking learning and evidence from elsewhere, implemented a flatter, collaborative structure within the Leadership Team also adopting a self-managing approach. Additional supports were implemented including team development sessions, a professional link, one to one coaching, and group Action Learning Sets, all to support the Leadership Team to manage their challenging roles in a supported and positive way.

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5. National Health and Wellbeing Outcomes

The nine national health and wellbeing outcomes are high-level statements of what we are trying to achieve as an integrated partnership. A core set of indicators are aligned with each of the outcomes (some indicators are aligned with more than one outcome) and help show us the progress we are making in delivering high-quality, person-centred integrated services.

How well are people in our city population looking after their own health and wellbeing?

According to the most recent statistics available for 2017, the Aberdeen City male and female life expectancies were 76.90 and 81.05 years at birth respectively, compared to 77.02 and 81.08 in Scotland. This slowdown in life expectancy improvement has affected the most deprived Scottish areas particularly, exacerbating the already very wide health inequalities.

Life Expectancy in Years at Birth for Scotland and Aberdeen City (1981-2017)

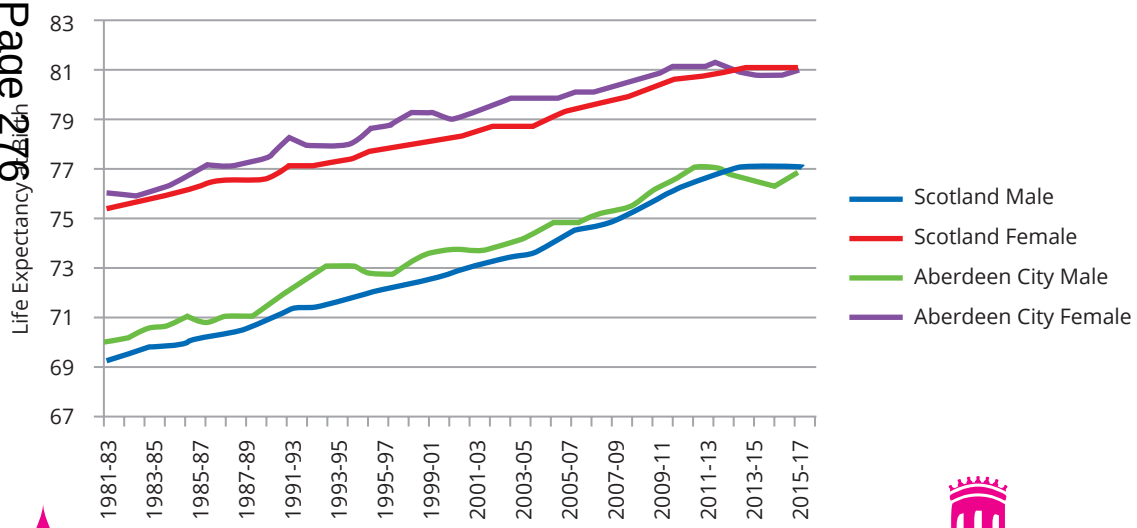

Table 6.1 Life Expectancy in Years at birth

Our premature mortality rate is reducing at a slower rate than the national figure. The change in national mortality trends has affected men and women, almost every age group, and almost every cause of death. It is a local concern that these avoidable deaths are mostly occurring in middle-aged people in the most deprived parts of Aberdeen. They also partially explain the worsening of life expectancy trends.

The use of hospital services in emergencies or unplanned situations gives us a good indication of the population's health and wellbeing.

Our emergency admission rates per 100,000 persons have decreased and are consistently lower than the rates seen across Scotland.

How well are vulnerable people in our city able to live independently at home or in a homely setting?

There is a basket of measures available which give us an indication about how well people with long-term conditions, frailty or disabilities cope with independent living and their reliance on formal supports and interventions. Most suggested a positive picture in this respect with only the % of adults with intensive care needs receiving care at home and the falls rate countering this impression.

- **Emergency admission rates decreased in 2018** to a level below that of the previous period.
- **A decrease** in the readmission within 28 days rate reverses to some extent the increase evident in 2017 although we are still higher than the 2016 rate.
- **Significant decrease** in the emergency bed day rate; 76,286 for 2018 compared to 82,302 for the previous reporting period.
- **Slight increase i**n the proportion of last six months in home or community setting.
- **Significant decrease** in number of days people spend in hospital when they are ready to be discharged.
- **Slight decrease** in the % of health and care resource that is spent on hospital stay following emergency admission. This decrease reverses last year's increase.

However,

- **Increase** in the falls rate 65+; 17 for the 2018 period compared to 15 for the previous reporting period.
- **Slight decrease** in the % of adults with intense care needs receiving a care at home service

How positive are the experiences of people who use health and social care services?

Improving the personal experiences of those of us who are using our integrated health and social care services is a key partnership ambition. We are making good progress in this respect given that:

- there is a slight increase in the proportion of last 6 months of life spent at home, or in community setting
- the proportion of local care services graded good or better has increased year-on-year, and
- there has been a significant decrease in the number of days people spend in hospital when they are ready to be discharged.

How are services centred on improving quality of life for people?

Similarly, we believe that we are making a positive and sustained improvement to the quality of people's lives, as shown by the following:

- Emergency admission rates **decreased** in the period April – December 2018 to a level below that of the previous period.
- There was a **significant decrease** in the emergency bed day rate.
- The proportion of care services graded good, or better **has increased** year-on-year over the past three years
- There has been a **significant decrease** in the number of days people spend in hospital when they are ready to be discharged
- there has been a **slight decrease** in the % of health and care resource that is spent on hospital stay following emergency admission. This decrease reverses last year's increase.
- Increase in the falls rate 65+.

It is worth highlighting again the significant contribution that our partners in the third and independent sectors make to the quality of lives of the people who use their services and their unpaid carers. **92% of local care services being graded as 'good' or better by the Care Inspectorate is a tremendous endorsement of our commissioned provision across all client groups.**

Table 6.2 Care Inspectorate Grades (Source: Care Inspectorate)

Quality Themes	Inspection Grades % (2017-18 %)					
	1	2	3	4	5	6
Care and Support (wellbeing)	**0.58**	**0.00**	**4.09**	**30.99**	**57.30**	**7.01**
Care and Support (planning)	**0**	**0.58** *(1.66)*	**4.67** *(3.88)*	**29.23** *(23.88)*	**58.47** *(58.33)*	**7.01** *(12.22)*
Environment	**0**	**1.72** *(1.38)*	**8.62** *(6.94)*	**25.86** *(26.38)*	**56.90** *(56.90)*	**6.90** *(8.33)*
Staffing	**0.63** *(0)*	**0** *(2.22)*	**7.64** *(4.44)*	**19.74** *(20.00)*	**60.50** *(61.11)*	**11.46** *(12.22)*
Management & Leadership	**0**	**0.64** *(2.22)*	**7.05** *(5.00)*	**30.12** *(30.00)*	**54.48** *(52.77)*	**7.69** *(10.00)*

This ongoing improvement is even more noteworthy when one considers that in April 2018, the Care Inspectorate launched the new Health and Social Care Standards which are significantly more rights-based, person-led and outcomes-focused than the previous standards.

There has been **a slight decrease in the past year in the number of upheld complaints and in the number of services with requirements.** More particularly, the housing support returns show a slight increase in the number of upheld complaints but a decrease in the number of services with requirements.

Services	Number of Services with Upheld/ Partially Upheld Complaints (2017-18; 2016-17)		Number of Services with Enforcements (2017-18; 2016-17)	Number of Services with Requirements (2017-18; 2016-17)
Adult Placement Service	1	0 (0; 0)	0 (0; 0)	0 (0; 0)
Care Home Service	58	6 (8; 7)	0 (1; 0)	5 (5; 6)
Housing Support Service	56	4 (3; 3)	0 (0; 0)	2 (5; 5)
Nurse Agency	8	0 (0; 0)	0 (0; 0)	0 (0; 0)
Support Service	59	3 (4; 1)	0 (0; 0)	1 (0; 0)
Total	**182**	**13** (15; 11)	**0** (1; 0)	**8** (10; 11)

Table 6.3: Complaints, Enforcements & Requirements (Source: Care Inspectorate)

We are the fourth best ranked partnership in the country for the quality of our commissioned services but we are mindful that other factors can impact on the quality and continuity of care that is delivered in our name. We have a dedicated team of Social Care Contract Managers and a robust process for contract management. Coupled with our focus on improving commissioning relationships and working in a more collaborative and supportive way, and the concerted efforts of our providers and the organisations that support them *(such as Scottish Care and Aberdeen Council for Voluntary Organisations),* we believe this impacts positively on this measure. We will never be complacent about this and will always intervene in the best interests of those individuals who are receiving care.

How well are we helping to reduce health inequalities?

We are aware that there are enduring health inequalities in the city. The indicators aligned with this outcome *(premature mortality rate and emergency admission rate)* both show improvements from previous years and have favourable comparisons with their equivalent national figures. We are, however, aware that an area of focus in terms of improvement are those avoidable deaths mostly occurring in middle-aged people in the most deprived parts of Aberdeen.

Improving the accessibility of our services and understanding the impact of our interventions with these population groups will help us tackle health inequalities and we have made addressing the factors that cause inequality in outcomes in and across our communities a specific commitment in our refreshed Strategic Plan.

How well are carers supported?

Improving our support for unpaid carers has been a pivotal ambition of the partnership from its early days. In comparison with the extent of positive feedback from the people who use our services, carers feedback is much lower both in Aberdeen and also across Scotland as a whole.

We are confident that the implementation of our new Carers Strategy will result in better experiences and outcomes and an improved opinion of how their role is perceived and supported. During 2018/19 we commissioned a local survey of Carers which was a repeat of the exercise we undertook when we were developing our strategy. Our Carers Strategy Implementation Group is tasked with understanding the responses to the survey and leading on their expected improvement.

How well do we keep people safe from harm?

Many of the measures described in the earlier sections also give an indication of how well we protect people from harm. The decrease in the emergency admission rate, the emergency bed day rate, readmission within 28 days rate and the % of health and care resource that is spent on hospital stay coupled with an increase in the proportion of care services graded good suggests we are moving in the right direction.

We recognise however that we need to understand better why our falls rate is increasing year on year.

How well do staff feel engaged and supported to improve the care they provide?

The "iMatter" feedback tool continues to be a key means of providing a measure of engagement, communication and motivation across the partnership.

The response to last year's questionnaire was 68% which is up slightly on the previous year when it was 65%. Our Employee Engagement Index score (EEI), which represents how engaged our employees are, was 78, the same as the previous year. Overall, employees rated working with the partnership as 7.05 out of 10, an increase from 6.94 the previous year.

The partnership has a Joint Staff Forum to discuss matters of common interest and concern to staff and their representatives. It provides a platform to develop constructive working relationships to ensure that our staff are at the centre of plans for the on-going development of our organisation.

In the past year the Forum has provided an "open" communication channel on a range of transformational activity; provided IJB feedback on key strategic documents; decided HEART Award Winners in two categories and overseen adherence to Organisational Change Policy.

An open call went out to all staff to ask for ambassadors/ staff to join in workshops about shaping the OD plan and identifying potential actions – this was also a way to discuss how we better communicate with staff.

How well do we use our resources?

The IJB has a responsibility under the Public Bodies (Joint Working) (Scotland) Act 2014 to set a balanced budget. The funds for the IJB are delegated from Aberdeen City Council (ACC) and NHS Grampian (NHSG) with the purpose of delivering the IJB's Strategic Plan.

The level of funding delegated to the IJB from its statutory partners at the start of the 2018/19 financial year was £315,156,732, an increase of £12,301,270.

The funding contributions from the partners exclude any funding which is ring-fenced for the provision of specific services, such as that provided for Criminal Justice.

Partner Funding Year	NHS Grampian	Aberdeen City Council	Total
2016-17	222,584,000	88,156,247	310,740,247
2017-18	217,686,633	85,168,829	302,855,462
2018-19	228,300,813	86,855,919	315,156,732

Table 6.4 Delegated funding to IJB

Table 6.4 shows the respective contributions made by our partner organisations, NHS Grampian and Aberdeen City Council.

The breakdown of spend across all of our activities in 2017-18 is shown in Table 6.5.

Sector	Gross expenditure £		
	2018-19	**2017-18**	**2016-17**
Older People, Physical and Sensory Impairments	74,255,297	72,882,926	69,719,818
Set Aside Services	46,416,000	41,344,000	46,732,000
Primary Care Prescribing	40,316,656	41,364,343	40,005,916
Primary Care	38,885,208	37,234,075	36,846,589
Learning Disabilities	34,621,408	31,269,790	29,264,461
Community Health Services	31,594,608	31,406,760	31,649,313
ACHSCP share of Hosted Services	22,330,324	21,724,509	21,207,851
Mental Health and Substance Misuse	19,992,884	20,065,177	18,304,741
Transformation	5,652,732	5,011,678	2,856,283
Criminal Justice	5,110,341	4,658,796	4,413,345
Housing	1,860,555	1,860,555	2,197,288
Out of Area Placements	1,689,920	1,480,487	1,219,506
Head Office/Admin	171,352	475,319	1,007,021
Cost of Services	**322,897,286**	**309,827,777**	**305,424,132**

Table 6.5 Expenditure breakdown by sector 2018-19

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The accounts for the year ended 31 March 2019 show a usable reserves position of £5,578,337. This is largely due to additional funding received in 2016/17 from the Scottish Government which the IJB is using on integration and change projects. A significant element of these funds has been committed and used in 2018/19. All of the recurring funding has now been allocated and the IJB had agreed through its Medium-Term Financial Framework to use these funds in 2017/18, hence the reduction.

Total Reserves £		
2018-19	2017-18	2017-16
5,578,337	**8,306,965**	**10,417,474**

Table 6.6 IJB Reserves

Set Aside	2016/17	2017/18	2018/19
Budget	**£46,732,000**	**£41,344,000**	**£46,416,000**
Days used	**152,498**	**142,349**	**143,055**

Table 6.6 IJB Reserves

The IJB has a notional budget representing the use of acute health services by the city's residents. It is envisaged that effective integrated service provision in our communities and localities will, over time, reduce the use of these acute health services. NHS Grampian has advised that for the past year, the partnership's use of these services had slightly increased as indicated below and that there had also been a budget increase due to movements in the price per bed days for the services.

Further work is being undertaken to determine possible explanations for the increase in the bed usage.

A proposed budget for 2019/2020 which outlined budget pressures, budget reductions and an indicative budget position for the next five financial years was presented to a special meeting of the IJB on 12 March 2019 by the Chief Finance Officer.

The proposed balanced budget was approved.

7. Looking Forward

Aberdeen City Health & Social Care Partnership
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Our overall performance this past year has been positive. We are pleased that our continuing efforts to reduce the number of delayed discharges is progressing well in the right direction. We are the fourth best ranked partnership in the country for the % of care services which are graded 'good' or better and our readmissions rate within 28 days has improved from its red status last year.

We recognise that there is still much to do. Two indicators - the percentage of adults with intensive care needs receiving care at home and the number of A&E attendances - give us cause for concern and they will be the focus of investigation and improvement activity this coming year. We will also focus on falls and avoidable deaths in middle-aged people in the most deprived parts of Aberdeen. In addition, we will use the results of our local survey to identify areas that we would wish to target for improvement and will look for evidence of that improvement to report in future years

We need to work with both Aberdeen City Council and NHS Grampian staff to develop a single reporting system that allows us to sensibly report on partnership complaints and compliments and staff-related data such as sickness absence and turnover.

We are excited to be launching the integration level Care Opinion module which will allow users of commissioned services to feedback their experiences on-line and we look forward to being able to report on this and using it to inform future service delivery.

The range and complexity of transformational activities that we are progressing this year has grown and diversified but we recognise that many of our changes are designed for the long term and so their impact will not be readily apparent to us just yet. We hope our new Leadership Team structure supported by our Workforce Plan will equip us for this challenge.

Our locality structure is changing and with this change the Locality Plans will be refreshed using locality specific data to identify areas of priority activity. From this work we intend that future Annual Reports will contain data down to locality or even neighbourhood level.

Sustainable improvements can only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce. As an organisation, we are looking at what we do and how we do it in order to be more effective and efficient.

We are introducing a co-produced, more outcome focused approach to commissioning. We are also embarking on an improvement programme known as SWIFT - Supporting Workforce Improvement for Tomorrow. Staff have been trained in Lean Six Sigma performance improvement techniques and these will be employed in improvement projects that have been identified and supported by staff themselves.

We hope to be able to report on the improvements achieved in our next Annual Report.

As mentioned earlier, the IJB approved our new Strategic Plan 2019-2022 in March. This plan has five Strategic Aims (Prevention; Resilience; Personalisation; Connections and Communities) and against each a number of commitments have been made and priorities identified. These capture the range of activities and developments that we will put in place to promote the health and wellbeing of our local population and the services that we provide to maximise this wherever possible.

A Strategic Implementation Dashboard has been developed showing the alignment between desired activities, objectives and themes. This also identifies which colleague in the Leadership Team has a responsibility for implementing that activity and the timescale for this. Progress will be monitored on a quarterly basis by the Chief Officer.

Strategic Performance Indicators incorporating local and national indicators have been aligned to each of the Strategic Aims and next year's Annual Report will articulate the degree to which the Strategic Plan's year one priorities have been delivered along with progress made towards subsequent years commitments.

Finally, we will seek to make significant progress on our MSG Self-Evaluation Action Plan aiming for 100% rated at exemplary level.

Appendix A - Performance Summary (National Indicators)

If Current position is the same or better than Scotland
If Current position is worse than Scotland but within 5%
If Current position is worse than Scotland by more than 5%

Indicator	Title	Aberdeen City % 2013-14	Aberdeen City % 2015-16	Aberdeen City % 2017-18	Scotland % 2017-18	RAG
NI - 1	*Percentage of adults able to look after their health very well or quite well*	96	97	94	93	
NI - 2	*Percentage of adults supported at home who agreed that they are supported to live as independently as possible*	82	80	82	81	
NI - 3	*Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided*	86	76	79	76	
NI - 4	*Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated*	80	74	76	74	
NI - 5	*Total % of adults receiving any care or support who rated it as excellent or good*	83	77	83	80	
NI - 6	*Percentage of people with positive experience of the care provided by their GP practice*	85	84	82	83	
NI - 7	*Percentage of adults supported at home who agree that their service and support had an impact on improving or maintaining their quality of life*	83	79	79	80	
NI - 8	*Total combined % carers who feel supported to continue in their caring role*	42	38	40	37	
NI - 9	*Percentage of adults supported at home who agreed they felt safe*	82	80	84	83	
NI-10	*Percentage of staff who say they would recommend their workplace as a good place to work*	76% 2017	76% 2018	76% 2019	-	

Indicator	Title	Aberdeen City % 2013-14	Aberdeen City % 2015-16	Aberdeen City % 2017-18	Scotland % 2017-18	RAG
NI-11	*Premature mortality rate per 100,000 persons (European age-standardised mortality rate per 100,000 for people aged under 75)*	464 (2015)	460 (2016)	423 (2017)	425 (2017)	
NI-12	*Emergency admission rate (per 100,000 population)*	7,526 (Apr-Dec 2016)	7,672 (Apr-Dec 2017)	7,627 (Apr-Dec 2018)	9,164 (Apr-Dec 2018)	
NI-13	*Emergency bed-day rate (per 100,000 population)*	85,564 (Apr-Dec 2016)	82,302 (Apr-Dec 2017)	76,286 (Apr-Dec 2018)	87,034 (Apr-Dec 2018)	
NI-14	*Readmission to hospital within 28 days (per 1,000 population)*	104 (Apr-Dec 2016)	117 (Apr-Dec 2017)	115 (Apr-Dec 2018)	103 (Apr-Dec 2018)	
NI-15	*Proportion of last 6 months of life spent at home or in a community setting*	89% (2016-17)	89% (2017-18)	90% (2018-19)	89% (2018-19)	
NI-16	*Falls rate per 1,000 population aged 65+*	15 (Apr-Dec 2016)	15 (Apr-Dec 2017)	17 (Apr-Dec 2018)	17 (Apr-Dec 2018)	
NI-17	*Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections*	86% (2016-17)	90% (2017-18)	92% (2018-19)	82% (2018-19)	
NI-18	*Percentage of adults with intensive care needs receiving care at home*	53% (2016-17)	55% (2017-18)	54% (2018-19)	61% (2018-19)	
NI-19	*Number of days people aged 75+ spend in hospital when they are ready*	1,155 (2016-17)	838 (2017-18)	605 (2018-19)	805 (2018-19)	
NI-20	*Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency*	26% (Apr-Dec 2016)	26% (Apr-Dec 2017)	24% (Apr-Dec 2018)	22% (Apr-Dec 2018)	
NI-21	*Percentage of people admitted to hospital from home during the year, who are discharged to a care home*	-	-	-	-	
NI-22	*Percentage of people who are discharged from hospital within 72 hours of being ready*	-	-	-	-	
NI-23	*Expenditure on end of life care, cost in last 6 months per death* - -	-	-	-	-	

Appendix A - Performance Summary (MSG Indicators)

If Current position is the same or better than Scotland
If Current position is worse than Scotland but within 5%
If Current position is worse than Scotland by more than 5%

Indicators	2015-16	2016-17	2017-18	2018-19	2018-19
Number of emergency admissions (18+)	*21,883*	*21,401*	*21,837*	*21,375*	
Number of unscheduled bed-days (acute; 18+)	*154,443*	*144,702*	*140,935*	*120,374*	
Number of unscheduled bed-days (mental health)	*66,559*	*63,078*	*61,031*	*56,302*	
Number of A&E attendances (18+)	*35,314*	*35,046*	*35,838*	*36,248*	
Delayed Discharge bed days (all ages)	*43,944*	*27,353*	*19,202*	*13,172*	
% of last six months of life spent in community setting (inc care homes)	*88.1%*	*88.9%*	*88.6%*	*N/K*	
Balance of care; % of 75+ population in community settings.	*95.3%*	*95.5%*	*95.6%*	*N/K*	

Glossary

Action 15 Action 15 of the national Mental Health Strategy 2017 -27 is to *"Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings."*

Acute Health Services Those secondary health care services normally delivered in a hospital setting.

Acute Speciality Various categories of surgical and medical services identified under a national code system e.g. Cardiology, Respiratory etc.

Advanced Nurse Practitioner An Advanced Nurse Practitioner is a registered nurse who has undertaken a specific course of study of at least first degree (Honours) level and who takes on additional roles and makes professionally autonomous decisions, for which they are accountable.

Bon Accord Care The Arm's Length External Organisation wholly owned by Aberdeen City Council responsible for the delivery of Older People's services in Aberdeen City.

Buurtzorg Buurtzorg Nederland is a Dutch home-care organisation which has attracted international attention for its innovative use of independent nurse teams in delivering relatively low-cost neighbourhood care. Buurtzorg is Dutch for "neighbourhood care".

Care at Home Care, normally personal care tasks, provided in an individual's own home by a paid carer.

Care Inspectorate The Regulatory Body for social care services.

Commissioned Providers Organisations normally in the third and independent sectors who deliver services on behalf of the partnership in return for payment.

Community Planning Partnership A group of key public, private, community and voluntary representatives working together with the aim of delivering better, more joined-up public services in the city.

Delayed Discharge Someone who is deemed fit to go home from hospital but whose discharge is delayed due to appropriate care and support not being in place.

Discharge Hub Hospital based, multi-disciplinary team whose role it is to co-ordinate care and support arrangements for patients to expedite their discharge from hospital

Emergency Bed Day Rate The number of days hospital beds categorised as emergency beds are occupied.

GMED An out of hours service that deals with non-emergency but urgent health needs of patients.

Health Improvement Fund	The Health Improvement Fund is part of the grant making function of Healthcare Improvement Scotland's (HIS) Improvement Hub (ihub), It will fund projects at a local level that improve the quality of health and social care services in Scotland.
Health Improvement Scotland	An organisation with many parts and one purpose - better quality health and social care for everyone in Scotland.
iMatter Survey	A staff experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience. Used by all staff in Aberdeen City Health and Social Care Partnership.
Intensive Care Needs	Multiple or long-term conditions
Life Expectancy	A statistical measure of the average time a person is expected to live, based on the year of their birth, current age and other demographic factors including gender.
Link Practitioners	Workers based in GP practices, whose role it is to make the links for people to services available in their community to meet their needs.
Localities	Natural communities within Aberdeen City where services are delivered in a targeted way based on need.
Mean Satisfaction Score	The score in the middle of a range of scores.
Neighbourhoods	Smaller districts or areas within localities
Peer Review	The evaluation of work by a colleague
Premature Mortality Rate	The rate of deaths for those aged 30 to 70 from certain potentially preventable causes
Primary Care	The first point of contact in the healthcare system e.g. GP
Primary Care Improvement Plan	As part of the arrangements for implementing the new GP contract IJBs were required to develop locally agreed Primary Care Improvement Plans which provide detail and funding arrangements for the six priority service areas due to be reformed over the 3-year lifetime of the plans i.e. Vaccination, Pharmacotherapy, Community Treatment and Care, Urgent Care, Additional Professional Roles, and Community Links Workers.
Step-Down Support	Support given to someone recuperating from an illness or intervention, whose care needs will decrease over time.
Step-Up Support	Support given to someone who has a slowly progressive condition which requires increasing levels of care.
Social Isolation	A state of complete or near-complete lack of contact between an individual and society
Unscheduled Hospital Bed Days	The number of days beds are occupied within a continuous hospital stay following an emergency or urgent admission.

Aberdeen City
Health & Social Care
Partnership
A caring partnership

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